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**PROJECT 17233:**

Intellectual disability (Compulsory Care) legislation

A thesis presented in partial fulfilment of the requirements for the degree  
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## **Abstract**

This study presents an exploration of the history of people who have an intellectual disability and the proposed Compulsory Care legislation that is currently before Parliament. The hypothesis posed is that the legislation is the result of a moral panic. An analysis of the components of a moral panic were identified and examined.

The history of the 'eugenics' era is outlined. This era involved the systematic marginalisation of intellectually disabled people on the basis that they posed a 'serious' threat to Western society. This period of history spanning the years 1880 to 1930 is examined for evidence of a moral panic. The 1950's to the present day are briefly reviewed for evidence of a continuation of eugenic thinking.

The process and progress of the Compulsory Care legislation is documented and analysed. The findings show there is some evidence to support the hypothesis but that it is insufficient to confirm the view that the legislation resulted from a moral panic.

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I need to acknowledge that this thesis would not have been attempted without my being made acutely conscious through association with people who have intellectual disability who have

been stigmatised and marginalised that their difficulties are primarily a consequence of what others have done to them. They have suffered and continue to suffer the results of poor service provision.

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## **Chapter One**

### **Conception and Structure**

#### **1.1 Preamble**

This research concerns the history and development of legislation to allow for the compulsory care of people with intellectual disabilities who either commit imprisonable crimes or act in ways that are considered dangerous to themselves or others or to property.

My interest in the legislation developed through my personal involvement with people who have intellectual disabilities and in my work that involves supporting people with intellectual disabilities who rendezvous with the criminal justice system as offenders. In 1992 I became an advocate for a man with an intellectual disability through the Citizen Advocacy programme in Auckland. The programme provides for one-to-one advocacy for people with intellectual disability who for varied reasons are considered to be at risk. The person with whom I was matched had been an inmate at a major prison and was at risk of re-offending and hence at risk of further incarceration.

Since the match began we have been involved in numerous criminal court cases involving court appearances too numerous to remember. Some of the charges have been minor, others quite serious. Those cases have often demonstrated the difficulties mentioned in later chapters that beset judges with regard to disposition. What to do with the person. Dispositions have ranged from being released, put under the mental health system, remanded to prison, and remanded to a psychiatric institution. These results have led to either the release of the person to a situation of homelessness or being placed in the care of human service agencies. The human service agencies have in the long

term always been unable to support this man. And, when the agency has failed in its support the usual result have been further court appearances by the man.

With the introduction of the Mental Health (Compulsory Assessment & Treatment) Act 1992 the number of people with intellectual disability who went through the mainstream court system increased, one of the reasons for calls by the judiciary for disposition options specific to people with intellectual disability. The number increased for the reason that the new legislation removed intellectual disability as grounds for being found 'mentally disordered'. Mental disorder is the term for a person who because of mental illness cannot understand the processes of the court. Such a finding by the court allows a defendant to be transferred out of the mainstream court system and along the mental health path, which is what had previously often happened to people with intellectual disability whose behaviour was sufficiently serious to cause concern at court hearings.

My involvement in the criminal justice system deepened, when, as an advocate, I began to support other people with intellectual disability who went to court as alleged offenders. This activity was a natural consequence of my involvement as an advocate in the Citizen Advocacy programme. With support from interested people, primarily in the Citizen Advocacy movement, and those who believed that the criminal justice system was not working in the best interests of people with intellectual disability a group was set up to support them in that situation. The group still exists and I still work as an advocate. The workload is increasing. People with intellectual disability are still being dealt with in ways that are archaic and inhumane. As Lutfiyya, (1992) has pointed out:

the criminal justice system holds the same beliefs and biases that can be found in our larger society. Although we like to believe that justice prevails...

this is not always the case in real life. It is not enough to insist that individuals with disabilities be treated the same as others within the criminal justice system. That system would still not work well for them and they would remain at great risk (p. 24).

Lawyers in New Zealand have little or no training in the field of intellectual disability. This has important implications for the alleged offender. Some lawyers are sympathetic to the concerns of disability while others are not. Those who are will often admit their lack of understanding of the issues for people with intellectual disability. Luckily they are willing to accept help and this often entails spending much more time 'getting to grips' with the problems associated with the defence of a person with an intellectual disability than the legal aid fee they are paid covers. Over the years a number of lawyers have been identified who are supportive in this situation. Unfortunately because most alleged offenders are poor and so need legal aid they get whoever is next on the legal aid list.

Similarly judges are an important concern. Over time a number have been identified who take the time to consider all of the issues, who listen to and even invite comment from any source if it will enhance the likelihood of a just outcome. At the other extreme there are those who by their actions one suspects simply do not like people with an intellectual disability. In the middle are those who identify the problems and then send them to prison or to a mental health facility simply on the basis that they have no other options available to them.

The problems of disposition are of extreme concern. Disposition means simply what will be done with the person when the court case is over. Often heard in a courtroom and beginning with phrases outlining the minor nature of the offence the judge will then continue on to say that with nowhere to go, prison is the only option available. The reasons for such a decision are many and can include a new perennial, that the

service agency where they previously lived will not have them back, and other service providers are usually unwilling to take the risk. Another is that the judge feels the service offered is not able to provide a guarantee of non-re-offending. One judge thought that prison would provide the asylum that the person needed.

When it is obvious that the person cannot understand the court proceedings they will sometimes be made a 'special patient' and confined to a mental institution, where they will wait out their time amongst those who are insane. They are not and cannot be treated because they are not sick. They are simply detained. Though the 1992 mental health legislation excluded intellectual disability as grounds for mental disorder some are detained in mental institutions because it is plainly obvious to the court that the person's cognitive functions are at such a low level that they cannot understand the court process. In this instance the Criminal Justice Act, 1985 comes into play instead of mental health legislation. The reason given is that there is an expectation of judicial fair play, which translated means that the defendant cannot be expected to receive a fair hearing if for some reason they are placed at a severe disadvantageous due to their personal situation.

Recently, in two cases, the persons charged were sent to institutions for the care of people with intellectual disability. One had only been at the centre for a few days before being charged again with assault on staff members. The centre refused to take the person back unless the guardians of the person gave the service carte blanche to do what they felt necessary to keep the person under control. That means restraint both physical and through the use of drugs. In some respects this scenario is a tragic comedy. In chapter five evidence is given to suggest that the cause of the behaviours considered dangerous, ie,

unstimulating and restrictive service provision, is exactly those offered by services to solve the behaviours. Naturally this response does not result in rehabilitation.

Yet when the prison sentence has been served or incarceration in a mental hospital has come to an end there is still often nowhere for the people to go. If they get a place in a human service the likelihood is that they will merely be getting back on the merry-go-round that inevitably leads back to prison or the mental institution. Another alternative is that the service agency provides services that are very closely akin to detention.

Therefore when legislation to provide compulsory care for people with intellectual disability was mooted I was naturally very interested, initially thinking that it might be a good way of solving the problems of disposition that had become part and parcel of my work as an advocate. I followed the course of the legislative process and slowly became convinced that it was not progressive legislation. It would simply absolve human service agencies of the obligation to provide services that dignified those who received assistance from them and protected their basic human rights and freedoms. My interest led to the research.

The result of my research into the proposed legislation, which was finally brought to Parliament on October 5, 1999, is the subject of this thesis. The proposed legislation is intended to force people subject to it to accept service provision whether they wish to or not. The legislation also provides some very punitive measures for those who resist. Those measures are obsolete and have been used in institutional settings for many years. It is known that such measures do not have a rehabilitative effect on the people that they are applied to. In fact, such measures are known cause the problems that the legislation is designed

to address. I was left with the unfavourable impression that it would do nothing to help those I support. Having seen the often-poor service environments that led to the behaviours deemed dangerous or criminal I became very concerned at what appeared to be a vicious merry-go-round that would not let these people off. The literature on moral panics seemed to provide a comprehensive theory on which to base this apparent overreaction.

Through personal involvement I had got to know a number of those who would come into the orbit of the new legislation. Though some were charged with serious offences in very many cases the actual details of the crime were minor. One example is that of a man charged with arson who set fire to one sheet of newspaper which he had placed in the top of an upturned tin rubbish lid that he had placed on the top of a refrigerator in a shed. When cases like this one come to court comments by judges relating to the potential dangerousness of the crime are quite common. Sitting in the courtroom, listening to comments made by the judiciary regarding dangerousness, while watching the person who has been charged with the crime brings home the difference between the person as seen by the court in comparison to the person I know. The basis for the two perceptions can only be put down to levels of knowledge. Without in-depth knowledge one often resorts to stereotypical thinking. People with intellectual disability have been the repository of much stereotypical thinking.

## **1.2 Outline of the thesis**

Chapter 2 summarises the elements of a moral panic as I discovered in the literature. The research and the analysis of the data will take into account the model and compare it with the empirical evidence to



determine how far, if at all, what actually happened conformed to the paradigm established in chapter 2.

Key ingredients of a moral panic include defining a threat to the values or interests of society. Next the media illustrates the threat in simple stereotypical form which coincides with and further inflames a swift build up of public concern. Finally, either authorities respond to that concern or the panic fades away (Thompson, 1998).

### **1.3 Research methods**

Chapter three outlines the methodology used in the research, that is, documentary research. The methodology for this research by and large dictated itself. Part of the research includes examining an historical era. This meant depending on documents written at the time and those written subsequently about that era.

Researching the development of the legislation has necessitated examining Ministry of Health documents relating to the perceived problems posed by a small group of people with intellectual disability, which first appear in Ministry files in 1992.

Moral panics also involve significant contributions from the media and in this research a scrutiny of the print media going back to 1990 was conducted. Court decisions, papers and books written on the subject of people with intellectual disability in criminal justice systems were examined.

## **1.4 Historical comparisons**

Chapter four reflects upon another time, ie the Eugenics period, that has been described by some researchers as a moral panic involving people described as 'mentally defective' which includes people with intellectual disability. The period extended from the late 1800,s to the 1930's. If as previously asserted the eugenics era was a moral panic then an investigation may provide information with which to compare present day society and the factors involved in the compulsory care legislative process. This chapter will identify key players, interest groups and the problems that beset western society at the time. Chapter four also views a later period, from the 1940's to the 1970's to identify the continued existence in the belief that eugenics is a valid principle.

## **1.5 Compulsory care legislation**

Chapter five, the data chapter, traces the process of the legislation through the Ministry of Health, which had the responsibility of preparing the legislation. It identifies and describes the activities of the various key players during the decade that resulted in the 1999 legislation. This includes the media coverage of events surrounding the impetus for and the process of creating legislation. The activities of the authorities, including government and the judiciary, are also outlined.

## **1.6 Analysis**

Chapter six will analyse the data presented in chapter five. The actions of the key players will be examined for motive. Questions relating to the rationale underpinning the decisions resulting in a legislative response will be posed and regarding the shape of that legislation.

Chapter seven will review the entire research project. It will reflect upon the reasons that drove me to embark upon this enterprise. This includes the gaping contrast between my knowledge, through personal involvement, of those who are likely to be subjects of the legislation and the more stereotyped manner with which the law treats them. Chapter 7 will also outline the implications as I see them for people who have an intellectual disability and are deemed dangerous or criminal if the Intellectual Disability (Compulsory Care) Bill is passed into law.

## **Chapter Two**

### **Theory**

Societies appear to be subject, every now and then, to periods of moral panic. A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people, socially accredited experts pronounce their diagnoses and solutions; ways of coping are evolved or (more often) resorted to. (Cohen, 1980, p. 9)

### **2.1 Introduction**

As discussed in the previous chapter a wide gulf exists between the view taken by the criminal justice system of persons with intellectual disability brought before it and the person I know. The criminal justice system sees a representative of a class of people, the intellectually disabled, with all the problems associated with intellectual disability. Problems including an inability to understand the court processes, a lack of ability in recognising the consequences of actions. It is the person who has the problem.

Individual judges may comprehend that the reason for the court appearance is often service failure but the judicial system itself does not make that distinction. The judicial system perceives people with intellectual disability as a group problem, hence legislation which deals with this group of individuals as if it were a homogeneous whole.

The legislation deals with people who have an intellectual disability as though they were different from other people. Through the removal of basic human rights and freedoms the legislation will reinforce notions of dangerousness and difference. The result can only be additional stigmatisation of an already marginalised section of society. The legislation has a tendency to segregate people with intellectual disability

from the wider community based upon preconceptions that are by and large imaginary. It seemed therefore that a sociological basis for the Intellectual Disability (Compulsory Care) Bill might be found in the hypothesis of a moral panic.

This chapter will study the theoretical basis of a moral panic. It will examine the characteristics of a moral panic their construction and how they develop.

(Thompson, 1998) asserts that moral panics do not have a long sociological history. The first published reference was in 1971, though panics have occurred for over a hundred years. He makes a distinction between the 'moral panics' of the 1970's and later and those of an earlier era. The latter moral panics are more frequent, one giving way to the next in rapid succession. They can be initiated by almost any event. Earlier moral panics, on the other hand, were both less frequent and tended to identify a single group of people as the problem. Modern moral panics encompass problems which relate to a variety of groups. Thompson (1998) gives an example:

panics about child abuse seem to call into question the very institution of the family and especially physical relations between fathers and their children, perhaps reflecting a general unease about masculinity and the role of the father. (p. 2).

Goode & Ben-Yehuda (1994) assert that the moral panic paradigm expands our comprehension of social structure, processes, and change. It connects concepts from a assortment of miscellaneous areas including those of "deviance, crime, collective behavior, social problems and social movements" (p. 29).

## 2.2 Definition

Any discussion of a subject needs to begin with a definition. Thus a moral panic may be defined as occurring when:

A group or category engages, or is said to engage, in unacceptable, immoral behaviour, presumably causes or is responsible for serious harmful consequences, and is therefore seen as a threat to the well-being, basic values, and interests of the society presumably threatened by them" (Goode & Ben-Yehuda, 1994, p. 31).

Cohen (1980) makes the point more succinctly stating that a moral panic arises when "a condition, episode, person or group of persons emerge to become defined as a threat to societal values and interests" (p. 9).

## 2.3 Characteristics of a moral panic

There are certain characteristics common to all moral panics, though there may also be some variance in the number and combination. A moral panic may be nation-wide or localised, it may seem to be a threat against the very fabric of society or may be spurious in essence (Goode & Ben-Yehuda, 1994).

Thompson (1998) identifies key characteristics of a moral panic. These include:

1. Something or someone is defined as a threat to values or interests.
2. This threat is depicted in an easily recognizable form by the media.
3. There is a rapid build-up of public concern.
4. There is a response from authorities or opinion-makers.
5. The panic recedes or results in social changes. (p. 8).

Moral panics appear most prevalent in times of social change and extreme social stress (Thompson, 1998). Hostile reaction to perceived threats become more likely and more heavy handed when the situation

appears most unclear (Cohen, 1980). Moral panics may be purposely initiated to hold the community together.

A general characteristic of moral panics is that the perceived threat is usually out of proportion to the actual threat. Goode & Ben-Yehuda (1994) assert that in many cases the threat is either non-existent or imaginary. Thompson (1998) takes the view that quantifying the extent of the threat may be difficult due to the subjectivity of the perceivers, but suggests however that disproportionality is as an integral part of a moral panic.

## **2.4. Cast of characters**

Folk devils, the media, state agencies, interest groups and the public are all members of the cast in a moral panic. Moral entrepreneurs are sometimes involved but are not essential.

### **2.4.1. Folk devils**

Folk devils are the “visible reminders of what we should not be” (Cohen, 1980, p. 10). Goode & Ben-Yehuda see folk devils as “the personification of evil. Folk devils permit instant recognition” (p. 28) adding “folk devils are created out of some existing and recognizable elements” (p. 28), but are then reshaped into an easily recognisable image by the media. Cohen (1980) states that “through symbolization, plus the other types of exaggeration and distortion, images are made much sharper than reality” (p. 43). He asserts that folk devils are created by depicting them in stereotype, by showing their actions to be ‘atypical’ whilst depicting the environment as a caricature of what is right and normal. He also asserts that those who label the folk devils, “have a ready-made stock of images to draw on” (p. 74).

### **2.4.2. Moral entrepreneurs**

Moral entrepreneurs are described by Goode & Ben-Yehuda (1994) as “organisers, activists, do-gooders, movement advocates who push for a given cause”(p. 20). They assert that moral entrepreneurs identify the deviant person or group and the damage to which they are subjecting society. They encourage action against the deviant person or groups often in the genuine belief that forcing the deviants to conform to do the right thing will be good for the whole of society.

Moral entrepreneurs believe that available solutions are unable to cope with the problem at hand. However they cannot cause the necessary changes alone and must work with social interest groups or specific segments of society to effect those changes (Goode & Ben-Yehuda). Moral entrepreneurs use many devices to generate and maintain panics. The media is used extensively in order to influence public opinion and legislators. Organisations and entire social movements may be formed in opposition to presumed threats. Moral entrepreneurs become involved in public debate through talks and seminars. They act to sway educators into approving ideologically acceptable curricula and attempt to discredit supporters of opposing viewpoints. Moral entrepreneurs will also attempt to have behaviours criminalised in order to embroil law enforcement agencies in the panic thereby affording legitimacy to their own claims (Goode & Ben-Yehuda).

Thompson (1998) asserts that the most important connection in a moral panic is between moral entrepreneurs and the lawmakers and never more so where politicians are themselves moral entrepreneurs. This connection becomes even more significant where the moral entrepreneur has a hidden agenda, although as Goode & Ben-Yehuda



(1994) maintain this is not always the case. It becomes important because it is difficult to ascertain the real motives behind the moral entrepreneur's actions. The politician may increase popularity by creating a moral panic as appeared to occur in the 1996 general election when Asian immigration was manufactured into a problem.

Thompson (1998) identifies moral entrepreneurs closely with interest groups, linking one with the other. Moral entrepreneurs become involved with interest groups, support them and sometimes create them for their own purposes. To support the hypothesis that a moral panic underpinned the compulsory care legislation this research will lean quite heavily on aspects of interest group participation. It will distinguish the interest groups involved in the process and progress of the legislation and their level of activity.

### **2.4.3 The media**

The media are an essential element in the development and maintenance of a moral panic. This is especially so in New Zealand with the geographical isolation of population centres and the often rural settings of the large psychopaedic hospitals. The media in this case plays a pivotal role in drawing together the isolated strands of concern and representing them as one homogeneous whole.

Cohen (1980) discusses how, in western industrial nations, the news is presented in ways that reflect the editorial philosophy of the particular media organisation distributing it. The commercial interests of the media play a significant role in the manner of presentation, as this will be reflected in its circulation.

The mass media plays an important role in identifying the moral panic and the folk devils. To do this the media must present the 'facts' in a fashion that stereotypes both the deviant and the upright and must create a sense of unease in the general population. One of the ways is

by exaggerating the problem, a ploy known to the public (Cohen, 1980). Another is by the use of emotive terminology.

Cohen (1980) describes how the media and moral entrepreneurs feed off each other. The media use experts, moral entrepreneurs and others with strong viewpoints for commercial and editorial prestige while entrepreneurs use the media to gain 'mileage' for their purposes and/or for personal gain.

The circumstances revolving about the issue of legislation for dangerous intellectually disabled people provides a wealth of expert opinion, psychiatrists, psychologists and legal academics being just a few examples. The activities of people with intellectual disability who also commit crime or a deemed dangerous also provide ample scope for the involvement of moral entrepreneurs. Public safety is one such area. Another is the fear of crime.

One more role of the mass media is to identify and reinforce the norms of society. What is and what is not allowed and acceptable. Who are and who are not deviant. In doing so the media has a tendency to reinforce stereotypical roles and to make concrete the differences between the deviant and the norm, where previously those differences were less visible. This process and the dramatisation of the deviance causes 'polarisation' to occur (Cohen, 1980). In effect a 'them and us' positioning.

The overall effect is the creation of a stereotyped person or group upon which further layers of labelling and stereotyping can be loaded. This may or may not have any connection with the reality.

#### **2.4.4 Control agents.**

Goode & Ben-Yehuda (1994) describe how in modern industrial states control needs to be formalised to prevent the collapse of the social

order. The control agents primarily include law enforcement agencies, the judiciary and the systems of punishment. And, whereas in small, primitive societies persons are the primary injured party, in the modern nation it is the state that requires retribution.

In a moral panic as the problem becomes magnified and the public require that 'something be done', the police and courts as the main agents of social control must react in a manner which the public and politicians deem sufficiently strong (Cohen, 1980).

The police particularly are identified as having to deal with the problem with sufficient force to prevent the breakdown of order. The courts must necessarily support the police, especially when the public and politicians identify the problem as requiring a powerful response. As with the mass media, the police and courts begin to dramatise the problem using language that raises levels of concern and solidifies the problem making it a 'them' and 'us' situation. Cohen (1980) notes that the media to further exaggerate the level of the 'panic' tends to use the language of the control agencies.

Thompson (1998) argues that a moral panic, because of the moral aspect, is considered to pose such a danger to the social order that increased regulation (law) and control (policy measures) must be used to bring about a return to normality.

Thompson also identifies three general components of response by control agents. These are diffusion, escalation and innovation. Diffusion is the spreading of the perceived threat from point of origin to outer areas. This may be done by the requirement of outer areas of control agencies to assist the threatened region or by identifying some activity within the outer region as being comparable to the original threat. However Goode & Ben-Yehuda (1994) observe that a moral panic can be localised. Diffusion therefore may not necessarily always be a

component of a control agents response to the perceived threat. In essence, escalation is the increased awareness and level of response to the perceived threat. Innovation is the search for new ways to deal with the threat.

#### **2.4.5 Politicians**

Thompson (1998) argues that politicians of all persuasions are prepared to 'play on the fears' (p. 6) of the general public in order to advance their personal or political careers, often by calling for a return to 'traditional' values or to a more settled moral environment.

Goode & Ben-Yehuda (1994) discuss the influence that interest and sector groups have upon the actions of elected politicians. Although some politicians acted to calm situations many "aligned themselves against a devil and on the side of the angels" and acted in "angry, self-righteous, vindictive, condemnatory and punitive" (p. 28) ways.

Another variable in the creation of moral panics is the political climate at the time. That is whether the governing party is of a conservative or liberal nature, and the proximity of the next election (Goode & Ben-Yehuda, 1994).

#### **2.4.6 The public**

Thompson (1998) makes the point that the public in modern societies is not generally incensed as a group by the actions of the deviant until a social problem is constructed by the moral entrepreneur and the media. Goode & Ben-Yehuda (1994) take a different viewpoint and argue that there can be no moral panic without some support from the public. There must be something in the public consciousness upon which the media can build. Goode & Ben-Yehuda assert that there must be "substantial or widespread" support by at least a segment in society that a threat is real for a moral panic to become active. However, Goode

& Ben-Yehuda maintain that moral panics can be of various sizes, either nation-wide or localised, pertaining to the whole of society or to particular sections. They also accept that there are other schools of thought that conflict with their own. Further Goode & Ben-Yehuda (1994) accept that public opinion may be only an echo of powerful interests.

Thompson (1998) argues that moral panics can be used in a substitute way for other issues that cannot or will not be raised. He asserts that the media, by and large, repeat and represent the powerful structures in society.

#### **2.4.7 Interest groups**

Thompson (1998) assigns interest groups an important role in moral panics. Described as “influential claims-makers, each with a set of interests or a political agenda” (p. 15) they are identified as playing a pivotal role in picking up on social anxiety and feeding that to the media. Goode & Ben-Yehuda (1994) agree that interest groups provide leadership and organisation and express the fears of the public.

Thompson asserts that one reason interest groups pursue the creation of a moral panic is to allow them to deal with other issues in an oblique fashion. An example given is the decriminalisation of homosexuality which is attacked through raising fears of increased paedophilia.

Goode & Ben-Yehuda (1994) discuss the idea that interest groups are often filled with people who inhabit the middle rungs of power, such as the police, professional groups and educators. Goode & Ben-Yehuda while agreeing with the idea that interest groups have their own agendas that may include personal or professional gain for its members also argue that many of the members will be driven by moral arguments in the pursuit of the group goal. They argue that as interest groups are

generally comprised of people in the middle rungs of power, any claim that the elite creates a moral panic (to divert attention from other problems) is not necessarily the case.

If interest groups are filled with people from the middle rungs of power and on the understanding that it is the professional groups which stand to gain most from a moral panic in terms of expanded financial and public support a question needs to be asked. Do such groups manufacture panics specifically to enhance their own standing or do they see themselves as middle class guardians of societies morals?

## **2.5 The theoretical debate**

Cohen (1980) discusses how moral panics acted to create deviancy. He describes an older tradition in defining deviancy. That definition was assumed to relate to society in its entirety. What was defined as deviant was generally accepted although latterly a newer more sceptical approach has been advanced by sociologists. This approach asks "deviant to whom? or deviant from what?" (Cohen, 1980, p. 12) Who is saying this and why? This perhaps is where moral entrepreneurs and interests groups play an instrumental role.

Goode & Ben-Yehuda (1994) describe the four territories that must overlap to create a moral panic. These are "*deviance, social problems, collective behaviour and social movements*"(p. 52). The 'moral' in moral panic is the part played by deviance. Social problems occupy the area designated as public concern. Collective behaviour is the 'fad' that suddenly occurs and which provides the volatility in a moral panic, and social movements provide the impetus and organisation needed to address the problem identified and alters social conditions.

Goode & Ben-Yehuda (1994) argue that a moral panic is different from a social problem mainly. One difference concerns the numbers of people affected. Where a moral panic can involve relatively few people a social

problem involves a significantly large number. Another aspect of moral panics in comparison with social problems is the sometimes short life of a moral panic whereas a social problem tend to be long lasting.

Goode & Ben-Yehuda outline the path wherein which moral panics can be turned into moral crusades and can, in fact, be both. Anyone or any group can initiate a moral panic. It does not require the input of a moral crusader or moral entrepreneur. However a moral crusade cannot occur without a crusader.

Goode & Ben-Yehuda (1994) maintain that whereas a crusade reflects primarily a moral position assumed by crusaders to a substantial social threat a moral panic may be out of all proportion to the danger it actually poses, as previously noted.

## **2.6 Summary.**

In this chapter the elements and the characteristics of a moral panic have been identified. The key roles of major players have also been outlined.

In the following chapters these factors will be explored in relation to intellectual disability and the compulsory care legislation. Following chapters will examine the hypothesis that the development of the compulsory care legislation has been the result of a moral panic.

## **Chapter Three**

### **Methodology**

#### **3.1 Introduction**

This chapter discusses the methods used in the research and explains why those particular methodologies were used.

#### **3.2 The process**

The idea for this research came naturally out of my work. During the last seven years I have been involved in supporting people with intellectual disability that become involved in the criminal justice system as alleged offenders.

During the early part of this period I had contact with Warren Brookbanks a senior lecturer in law at Auckland University Law School. Through court cases which involved us both he subsequently became an important part of the legislative process by providing the Ministry of Health with a discussion paper on 'stand alone' legislation for people with intellectual disability.

I made contact with others who were key persons through attending conferences on the subject of 'compulsory care'. I attended two conferences in 1998, one in Wellington and one in Dunedin. Both are identified in chapter five. I was also invited to one 'Advisory Group' meeting which I attended in 1998.

During the years that the legislative process was occurring the organisation of which I am a member made submissions on the



legislation from the perspective of advocates for people who might be subject to it if it were passed into law.

I decided that the legislation would make the ideal topic for my thesis. However, I also realised that there was a need for a more systematic approach to the research. I began by collecting newspaper and magazine articles. I learned from the Ministry of Health that it was charged with preparing legislation.

When contacted the Ministry of Health staff were very helpful and I received permission to review the 13 folders of papers relating to the legislation. I received good co-operation and was allowed to photocopy any material necessary for the research. One difficulty that arose in my contact with the Ministry staff was their changing roles. Since my review of the Ministry papers there has been a change of staff. A consequence of these changes has been a request from the Ministry for chapter five to be submitted for examination prior to completion of the thesis.

I reviewed the Ministry's papers, which included references to concerns raised by the judiciary and some newspaper reports.

Lastly, I wrote to members of the 'Advisory Group' asking them a number of questions. These included:

1. Were you in favour of Compulsory Care legislation for people with intellectual disability?
2. Have you changed your opinion over the period since you were first involved?
3. Whether you have changed your opinion or not would you please identify your present position and outline why you hold it.
4. If you have any views that you feel may be helpful in my research I would appreciate hearing from you.

Letters were sent to ten members of the 'Advisory Group'. Four responded. One regretted not being able to assist due to other

activities, three gave feedback on the questions. These will be referred to in chapter five.

### **3.3 Vetting the research**

As previously stated this research required gaining access to Ministry of Health files on the progress of the legislation and their discussions with human service agencies, other professionals and academics. Permission to access the files was not difficult to obtain. However the Ministry subsequently requested that the data chapter be sent to them for their examination. The data chapter was duly set to the Ministry of Health. On 15 October 1999 I had a brief meeting with a high-ranking member of the Ministry at which the data chapter was briefly discussed. In general the Ministry was satisfied with the way the material had been handled. However it was requested that names be deleted and substituted with titles. Also that one particular phrase which was 'stupid'<sup>1</sup> on the part of the writer be deleted. This deletion has been done.

Further contact ensued. The Ministry offered more comments on Chapter five. In some cases the comments were very helpful and were duly incorporated into the chapter. Others were considered not so helpful and left out.

### **3.4 Research**

Documents have always been used in association with other methods. In principle documentary research is no different from other social science research, requiring a disciplined and systematic approach, with some specific techniques for analysing the material (Scott, 1990).

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<sup>1</sup> Ministry of health official's comment.

The research required accessing documents from the Ministry of Health. The National Library provided old parliamentary debates, e.g. the 1911 Mental Defectives Bill, and Appendices to the Journals of the House of Representatives. City libraries supplied backdated copies of daily and weekly newspapers.

Research projects rarely follow the expected route no matter how well intended and organised the researcher. Frost and Stablein (1992) suggest that they:

have learned that doing research is a much messier and more imperfect endeavour than most official sources of information about the process recognise or admit. It is also more personal. People doing research become intrigued, excited, frustrated, and depressed along the investigation trail. They experience despair and exhilaration. They are often puzzled and surprised by what they find (p., xii).

My involvement with the legislative process may be identified due to a desire to bring about the best outcome for those people who I support in my work, people who would almost certainly become subject to the legislation if it were passed. Initially my belief was that some kind of legislation was necessary. However as time passed and the nature of the legislation became clearer my viewpoint changed. I began to believe that the legislation would be used as a method to dispose of difficult people. That the major problem was insufficient quality in the services provided. Ministry of Health papers confirmed that poor services were a major problem, yet the Ministry did not leap to the conclusion that service provision should be improved but that the people must be compelled to accept the services regardless of quality.

At that point my decision was to oppose the legislation, which I have since done consistently. Yet my concern is not with legislation per se, but with this particular legislation.

### **3.5 Research method**

Research methods are many and varied. For example face to face interviews may be conducted and are by their very nature intrusive. At the other end of the spectrum the researcher may be an observer and be at pains to remain anonymous and even unseen, for fear of disturbing the natural balance existing in the particular situation under investigation. Other methods are quantitative surveys or questionnaires used to identify trends or general beliefs while at the other end of the continuum a researcher may study one person's life to gain personal insights into many questions.

The method employed in this research is documentary. The decision to use documentary research as the main method arose for a number of reasons.

In the first place this research takes the view that Compulsory Care legislation for people with intellectual disability is the result of a 'moral panic'. It is therefore useful to examine another period of time that has been described as a 'moral panic', concerning a similar group of devalued people. Comparing that era with the present may help in identifying common features. The era, known as the 'eugenics' period, began just over a hundred years ago and ended in the 1930's (Trent, 1994; Fleming, 1981). Documentary evidence is nearly all that is left with which to examine this era. Chapter four then is an historical survey of that time.

Chapter five brings together documents located at the Ministry of Health, media reports, information regarding conferences and research referred to in the ministry files in a chronological format. The

documents produced during the legislative period are presented in order to unravel the historical genesis and development of this piece of legislation.

A third reason for depending on documentary evidence was prompted by the duration of the legislative process, which spanned nearly a decade. Many people involved have since moved to different areas of endeavour and some of the people involved may have changed their opinions about the need for the legislation<sup>2</sup>. Nevertheless, the documents still exist. They reflect the authors thinking at the time of writing. They may also reflect the thinking of other persons not directly involved in the process, as in references to them made by the writers. A cautionary note must be added here. Though a great deal of material was made available some material may have been withheld whilst other material may already have been discarded. Further, I was not present at Ministry of Health and other relevant meetings. Therefore the analysis is based only upon information made available at the time.

Chapter six analyses the raw data presented in chapter five, using a process of content analysis. This is another reason for relying on documents in this research.

A fifth reason documentary research has been chosen pertain to the role professional and academic people play in creating and maintaining the 'moral panic'. An examination of the material written by those known to be involved in the legislative process is essential. Practically all are identified from an invitation to them by the Ministry of Health to assist in discussions on the legislation and who subsequently became the 'Advisory Group'.

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<sup>2</sup> Personal discussion with key people involved in the legislation

The sixth reason underlying the dependence on documents rather than personal interviews and questionnaires concerns reasons of confidentiality. People associated with the processes involved in this legislation are often not permitted, by reason of confidentiality or employment, to speak about the legislation and their perceptions of it. Ministry of Health personnel is one example of this.

One drawback in using documents is that they may fail to describe the intensity of debate or disagreement activated by this legislative process.

### **3.6 Documents**

Official papers, biographies, newspapers, books and articles are all documents. Added to the range are physical, non-verbal information such as works of art, clothing, and household items (Singleton, Straits and Straits, 1993) and "the entire range of human communication, from gestures to textbooks, from billboards to television commercials" (Chadwick, Bahr and Albrecht, 1984, p. 239).

Documents have also been classified diversely. Classical historians have tended to divide documents into two broad categories, testimony and social bookkeeping (Singleton et al, 1993) whilst recent researchers have classified documents more broadly (Scott, 1990).

Documents not principally developed as a source for the study being undertaken are referred to as secondary sources and their analysis as secondary (Sarantakos, 1998). This research uses almost exclusively documents that fall into this secondary category. Newspaper and magazine articles, official papers and internal Ministry memos, letters, journal articles and books have been penned for various reasons and

different audiences. They have not been produced explicitly for this research.

In relation to documents there are two types of 'access', 'direct' and 'mediate' (Scott, 1990). Direct access is where the researcher is at the scene of the activity, is able to view the occurrences and may even be taking part. At the very least the researcher is a contemporary of the event and is able to use his or her senses to observe and query the activity.

Examples where the researcher had 'direct' access included a workshop run by the Ministry of Health in relation to the proposed legislation and at conferences where key people could be identified and in some cases influenced. Other examples of 'direct' access include participation in specific court cases that resulted in comment from the judiciary and coverage in the media.

Mediate, or indirect, access relates to an activity, which occurred previously, where the observer must use the 'material traces' left by the actors, and in the structures of the past. In this case the observer and the observed are not 'co-present' (Scott, 1990). In this particular area, as already described, is literature from the past, both distant and recent. Much of the recent documentation is written by committees e.g. Ministry of Health, and therefore the authors are not available for interview or are domiciled elsewhere, and not available.

Some documents are easily available, as through public libraries. Some are available to a restricted group of people, such as Ministry of Health staff, or bona fide researchers, while others may be restricted to all. Such documents might include official state papers. Documents may also change their status. State papers may become available after a

predetermined period of time; personal diaries may be given to a library and become available (Scott, 1990).

An important aspect in relation to information given by the Ministry of Health is what Hill (1993) describes as 'closed stacks'. These are archival materials that have restricted access and are often brought to the researcher, as was the case with the Ministry papers. Hill asserts that the opportunity to give a false picture through the manipulation of papers made available is a factor, which must not be overlooked.

Another aspect of documentation is that described as 'soundness'. A document may be unsound due to poor quality transcription, damaged or unreadable passages, or where passages have been edited or deleted (Scott, 1990). In the present research the only obvious editing or deletion has occurred as part of the Ministry of Health's request that certain information not be made available to the reader.

### **3.7 Advantages and limitations in documentary research**

Documentary research enables the study of past events where no other avenues of research are available, (Scott, 1990; Sarantakos, 1998; Singleton et al, 1993; and Chadwick et al, 1984) which is crucial in this research where an historical survey forms a major component.

Secondly documentary research is more economical than other research methods and the information is usually valid and of high quality.

In the third place the researcher is able to revisit the investigation and the methods used do not change the outcome, while spontaneity is maintained as the authors have not produced the document for the researcher thereby contributing to a reduction in researcher bias.



A fourth advantage is that documents provide needed information where the researcher is prevented from being present to observe events (Chadwick et al, 1984). In this research considerable discussion occurred within government departments, institutional settings and 'Advisory Group' meetings in cities and venues that were restricted to specified parties and persons.

A fifth benefit of using documents entails being able to incorporate a wider, larger or more dispersed group of people and events into the research (Singleton et al, 1993). For example in the volumes at the Ministry of Health are documents written by many different people, residing in many different locales. Making personal contact with each person would be beyond the resources of this research project.

Limitations in documentary research include issues of reliability and/or bias. Documents may be incomplete, not representative of their type or difficult to access (Scott, 1990; Singleton et al, 1993). As examples Sarantakos (1998) identifies, "private letters, diaries, etc" (p. 277). The researcher is not always able to make comparisons between documents, nor go back to the writer for more information, or perhaps clarify what the writer actually meant. Therefore inferences must be drawn from documents (Sarantakos, 1998).

This research analyses the documents written by people who issue from a broad array of social backgrounds and who perhaps have a wide variance of attitudes and opinions regarding people with intellectual disability.

To discover today's social problems there is a need to look at historical events (Hill, 1993). The questions to consider include what was the

state of society at the time, what were the problems faced and is it possible to make comparisons with the present day?

Those who played a major role during the 'eugenics period' are now deceased. However the documents they wrote or caused to be written, the laws that were passed and that reflected their beliefs and the buildings erected on the basis of their opinions still exist, if not in fact then in photographs and drawings.

Documents in the Ministry of Health's files make reference to historical factors. An example concerns the process of and problems associated with deinstitutionalisation of the intellectually disabled over the previous decade<sup>3</sup>. The 'Principle of Normalisation'<sup>4</sup> and International covenants on human rights<sup>5</sup>, which specifically address issues relating to people with disabilities are mentioned.

### **3.8 Content analysis**

Documents reflect and are part of the social environment of the times (Chadwick et al, 1984; Scott, 1990). Scott adds that it is impossible to interpret documents objectively and that all "social events are of course 'distorted', as there is always an element of selective accentuation in the attempt to describe social reality" (p. 22).

Content analysis is a qualitative research method concerning the "dynamic process of gathering, thinking, evaluating, analysing, modifying, expanding, gathering further, thinking again and so on" (Sarantakos, 1998: p. 295).

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<sup>3</sup> Needs, Supports and Services: People with Intellectual Disability Who Have Challenging Behaviour. A research Project Commissioned jointly by the Central and Midland Regional Health Authorities. August 1995.

<sup>4</sup> A philosophy associated with returning institutionalised people to the community

Sarantakos asserts that content analysis concerns such ideas as “motives, attitudes or values” (p.280) and identifies two levels of content in any document, the ‘manifest’ and the ‘latent’. The ‘manifest’ consists of the written word, what they actually say. The ‘latent’ is what may be inferred or deduced from the information. The underlying meaning of the writer. Here the researcher has to read the hidden messages and therefore needs to understand the environment in which the document was written and where possible the author’s personal viewpoint.

The analysis of the data in chapter 5, therefore, entails identifying themes and belief systems, which underlie the words in the ministry documents, papers and comments from other agencies and the press coverage that would indicate the existence of a moral panic. The analysis occurs in chapter six.

It is important for the social researcher to assess the quality of the evidence offered. Scott (1990) offers four techniques for the purposes of appraisal. These are “authenticity, credibility, representativeness and meaning” (p. 19).

By authenticity Scott means is the evidence genuine and of unquestionable origin? Credibility involves establishing whether the evidence free from error and distortion. Representativeness necessitates substantiating the typicality of the evidence. Lastly, meaning requires verifying the clarity and comprehensibility of the evidence.

Scott (1990) maintains that these are not separate stages in document assessment but “are interdependent and that the researcher cannot

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<sup>5</sup> E.g. United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities, 1993.

adequately apply one criterion without simultaneously invoking the conclusions derived from applying the other three” (p. 35).

### **3.9 Legislation**

In analysing legislation several issues must be taken into consideration. For example the ‘author’ will probably be more than one person. In a sense the Minister is the first author. Then Ministry staff will convene meetings with interested people, groups and organisations that have a stake in the legislation’s outcomes. Each person or group will have different viewpoints. The Ministry will also be bound by certain other legislative, political and/or policy considerations. Finally the legislation will be drafted using legal jargon. Lastly and importantly it is necessary to recognise that the legislation has a political slant. For instance if the government does not wish to spend vast sums of money on the services that are deemed necessary in the legislation, then the type of care facilities will reflect this viewpoint. Another instance concerns the value placed on people. Should that value be based upon the productive capacity of a person the people subject to this legislation will be seen as being of little value and the legislation will reflect this particular view.

Legislation has its own language. There is opportunity to cover unpopular ideas with a mantle of respectability, using legal terminology. An example in compulsory care legislation, under the heading of Principles, section 7 (Appendix A), is the phrase ‘safeguarding of that person’s rights’ in relation to a person subject to the legislation. However this legislation has the power to remove the ‘rights’ of the person.

### **3.10 The interpretation of historical data**

Part of this research includes an analysis of a previous era when people with intellectual disability were treated as dangerous to society. The period known as the 'eugenics era', encompassed a time spanning the late nineteenth century and including the first four decades of the twentieth. To identify a moral panic the researcher must have an understanding of the social milieu in which the panic arose. Singleton et al (1993) give an example of understanding the social context surrounding a moral panic when they describe the witch burnings in Salem, Massachusetts in the seventeenth century. They identify that there was a threat but that it did not emanate from the so-called witches. Rather there was social breakdown caused by internal strife between village leadership, land disputes and trouble with the British crown. The witch-hunt was used to reinforce the moral boundaries that had previously encompassed the village. However, Singleton et al (1993) also argue that using the same facts of the Salem Witch Hunt many other conclusions may be drawn. It is important, therefore, where possible to identify others who have researched the eugenics era for evidence that a moral panic was in progress.

### **3.11 Conclusion**

This chapter has identified the process, which led to the research. It has discussed the research method used to outline the data chapter and the method used to analyse the data. Chapter four will trace the history of the 'Eugenics era'.

## **Chapter Four**

### **History**

#### **4.1 Introduction**

The historical positioning of people with intellectual disability has been one of marginalisation. The stereotypical view has included many negative aspects. They fill many roles which are devalued in western society. In a society that values riches and intelligence they are devalued through their poverty and intellectual incapacity. They have been portrayed as menaces and as objects of dread, viewed as a threat to society and to themselves (Wolfensberger, 1991).

They embody society's worst fears and prejudices: they seemingly not only lack the understanding and intelligence which define the basic qualities of humankind but also can be represented as a grave threat to the ordered running of a civilised society. They are the deformed, evil, and sub-human beings of folklore and, like goblins, trolls, and witches, they are irredeemably corrupt and perverse" (Glaser, 1996, p. 227).

The theoretical basis of this research situates people with intellectual disability at the base of a moral panic directly linked to the perception of them as a group as different and deviant. This research is not about the long history of people with intellectual disability. It concerns their more recent history where they have been defined as 'dangerous' to society.

Dangerousness has been attached to them due to the societal perception of their criminality and the threat of racial degeneracy they were believed to cause through breeding. These ideas will be discussed in this chapter in an examination of the Eugenics period. This chapter investigates that era and argues that eugenics, as a movement was an outcome of a moral panic with a specific focus. Further, this chapter

argues that the Eugenics era had and continues to have a persuasively negative effect on the lives of people with intellectual disability.

The intellectually disabled have, as a group, long been exiled to the margins of society (Wolfensberger, 1991). However, they came to prominence as a sub class and were seen to pose a threat to society at the end of the nineteenth and the early part of the twentieth centuries. The 'eugenics era' as it has been termed was a disastrous time for the intellectually disabled (Judge, 1987). It was the educated and professional classes who initiated the alarm regarding the threat posed to society by the alleged human degeneracy of the intellectually disabled (Wolfensberger, 1988, p. 68). The objective of this elite was to have the eugenic theory concerning heredity put into social policy in order to prevent the debasement of human beings (Trent, 1994).

This was a time of turmoil and fear of the future. America had just passed through a serious economic depression, and the nation was being flooded with immigrants from lands that were not the traditional sources. White American labourers had to compete with black labourers from the south for scarce jobs. The industrial revolution was at its height and a new century was dawning. Additionally there was a fear of Asian people outnumbering the white races and overtaking them both industrially and physically. Of considerable concern therefore to eugenicists, politicians and health administrators was the cost to taxpayers of supporting an increasing number of 'unfit' people who could not or would not look after themselves (Trent, 1994). Fleming (1981) asserts that the same concerns affected New Zealand eugenicists, politicians and administrators.

## 4.2 Science and pseudo-science

Darwin's work on evolution spawned other theories on evolution that were less intellectually rigorous (Judge, 1987). Social Darwinism was one example. Social Darwinism incorporated concepts in Darwin's theory of natural selection but with reference to society. Major supporters of these theories in the United Kingdom were Spencer, and his belief in the 'survival of the fittest' and William Sumner in America, who was a leading theorist. Spencer, Sumner and others were concerned with the notion of purifying and perfecting the human race. Judge (1987) asserts that many who followed in Darwin's wake "came to conclusions more general and facile than Darwin's intensely scientific study" (p. 40). Francis Galton, a cousin of Charles Darwin, had theorised about heredity, but his book *Hereditary Genius* was considered by Darwin to be without intellectual merit (Judge, 1987). Darwin considered evolution to be a natural process occurring slowly over long periods of time. The eugenic movement on the other hand considered that the danger to western societies from the gene pool of people with intellectual disability was so great that the state needed to intervene (Fleming, 1981).

Other academics including Lombroso, Mendel and Weismann pursued a scientific interest in heredity and eugenics. At the same time as eugenics, euthenics, a theory promoting the reproduction of superior human beings, supported the belief that with proper breeding techniques much that was wrong with the human race could be eliminated. The problems included intellectual disability, crime and vice, which were later linked together (Trent, 1994).



Cesare Lombroso, an Italian physician, became deeply involved in the fields of biology and criminology and created a connection between certain disabilities, e.g. epilepsy (Lombroso and Ferrero, 1895), idiocy and mental illness (Turck, 1914), with genius, and crime. With others who were, at the time, regarded as leaders in their chosen professional fields Lombroso brought together disability, crime and a belief in the deterioration of the human condition. He believed that 'idiots' could not be equated with those who personified the highest human ideals.

Glaser (1996) cites a well-known and respected President of the American Association on Mental Deficiency, Walter Fernald who in 1912 wrote that all intellectually disabled people were potential criminals and that given the right environment they would act out their criminal tendencies. Fernald went further, arguing that criminals and the intellectually disabled had a common heredity. Supporters of eugenics promoted research that supported these beliefs. Certain researchers used doubtful methodologies in the research. For example some research began with the proposition that criminal tendencies and immorality were primarily caused through mental defectives breeding. The researchers then worked back from this premise to prove the theory.

A review of the literature shows that studies and surveys carried out in correctional institutions were used to validate the hypothesis that mental degeneracy led to criminality (Scheerenberger: 1983). In one instance research carried out on a family named Jukes, made famous by the research, found that poverty was the primary cause for this dysfunctional family. Yet eugenicists picked out the points that helped them prove mental degeneracy was the cause. The environmental evidence was conveniently forgotten (Kevles, 1985). New methods of

assessing mental deficiency were also used to reinforce the threat from the intellectually disabled (Trent, 1994).

Walter Fernald, cited above, in the last years of his life retracted his stated belief in the potential criminality of people with intellectual disability and asserted that the intellectually disabled were not given to crime (Wolfensberger, 1999). It is quite possible that Fernald used some of the research carried out by Lombroso. Lombroso's work, which at the height of his career compared favourably with Darwin's, was later refuted by another expert Hermann Turck (1914). Unfortunately such retractions and refutations did not help the plight of the intellectually disabled at the time, and it is probable that much of the faulty research and beliefs of that previous era have come back to haunt the intellectually disabled in the present legislation.

The work of Gregor Mendel (Judge, 1987) and August Weismann (Fleming, 1981), both biologists, is cited in support of positions taken by the Eugenics movement. Both worked in the field of genetics and heredity. Their work, centring on how genes are inherited, added scientific support to the Eugenics movement call to prohibit reproduction in families tainted with intellectual disability.

Though statistically few people were involved with the theory of eugenics and the movements born in its name, those who were involved tended to wield great political and academic influence. Trent (1994) cites a very prominent academic, Professor Charles Eliot Norton, a former president of Harvard University, who favoured "painless destruction" (p. 134) for the mentally retarded and the mentally ill. Included in the list of the many prominent politicians in America who supported either in part or wholly, the eugenic idea, were Woodrow Wilson and Theodore Roosevelt, both onetime American Presidents.

The eugenics movement and related fields included both optimists and pessimists (Fleming, 1981). Some saw the opportunity, through eugenics, to create an increasingly higher quality of human stock with which to populate the western world.

There were others who believed that western civilisation was doomed unless the tide of increasingly 'unfit' people was stemmed by removing the threat of human degeneracy. The 'unfit' included the mentally ill, epileptics and the intellectually disabled, those who were diseased at birth, the deformed, the deaf and the blind (Fleming, 1981).

The mentally deficient were at this time being fitted into a number of categories. One category known as the 'moral imbecile' was defined as those unable to control their impulses. These impulses were presumed to be associated with criminal behaviour and expressions of sexuality. A caption on a photograph states, "of late we have recognised a higher type of defective, the moron, and have discovered that he is a burden; that he is responsible to a large degree for many if not all of our social problems (Wolfensberger, 1975, p 11). The photograph is circa 1920. Blatt (1987) discusses the persistence in the belief that "low intelligence more often than not leads an individual to moral degeneracy" (p 76).

### **4.3 Creating the 'Folk Devils'**

In the ten years 1910 to 1920 Americans came to view the intellectually disabled differently to any other period in their history (Trent, 1994). From the role of a burden on society the intellectually disabled person came to be identified as the principal cause of the evils associated with a perceived decline in moral and physical aspects of the citizenry. It was argued that through heredity, the basis of the eugenics philosophy, the

mentally retarded who were considered prolific breeders of more retarded people were placing the western world in jeopardy. As previously mentioned there was at this time great concern about the perceived threat from the Asian hordes. The eugenics movement believed that to counter this threat there needed to be a reliance on a superior breed of western man.

Judge (1987) quotes Oliver Wendell Holmes, "the great American jurist" in relation to a court case for sterilising a woman with intellectual disability, who had given birth to an intellectually disabled child and was herself the daughter an intellectually disabled mother. He stated that:

it is better for all the world, if instead of waiting to execute degenerative offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind... three generations of imbeciles are enough" (pp. 49-50).

As earlier described it was the people with power who decided the fate of the intellectually disabled. Many of those working in the province of mental deficiency were proposing the total institutionalisation of the intellectually disabled as a means of combating the deterioration of the racial stock, and the increasing rates of crime and poverty. (Trent, 1994). People who worked with the intellectually disabled fostered "moral panics on a national scale" (Glaser, 1996, p. 195). James Trent supports this view stating that the "early-century eugenics scare in North America was an example of a moral panic"<sup>6</sup>.

Hartley (1995) asserts that in the late 19th century asylums were made larger primarily "for return on capital and economy of scale reasons" ... and that provision was focused on "custodial care rather than treatment, in essence warehousing" (p 8). Society does not know how to deal with people who need supervision and care and those with

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<sup>6</sup> Personal communication by email

intellectual disability were, in many institutions, simply relegated to the 'back wards' (Judge, 1987). The population explosion, which coincided with industrialisation, put a great deal of pressure to expand and as the institutions grew larger the negative imagery attached to them helped perpetuate the myth of the inmates as a social threat (Oliver, 1990).

In the early part of the 20th century two schools of thought pervaded the eugenics movement in relation to dealing with the problem of the 'unfit'. One idea supported the practice of segregation, or institutionalisation, the other sterilisation was considered by many to be the cheaper option in preventing further unwanted needy persons (Fleming, 1981).

As previously mentioned there were those supporters of eugenics that believed in the 'painless destruction' of the unfit. However preventing the unfit from breeding or of being a threat to society usually stopped at policies of segregation and sterilisation. In Nazi Germany however the policy of preventing the unfit from breeding stopped only at death, a barbaric but logical conclusion if the belief in the threat of unfit is strong enough. The mentally ill and the intellectually disabled were the first groups put to death in Hitler's Germany. Perhaps because of their extreme devaluation in the western world very little has been said about this 'holocaust'. "As we learned from the Nazi experience, persecution and extermination inevitably follow group declassification of human beings" (Wolfensberger, 1975, p 45).

#### **4.4 The New Zealand experience**

In New Zealand the scientific data about Eugenics from England and America was accepted without question by supporters of Social Darwinism (Fleming, 1981). New Zealanders believed that they shared

the same fundamental problem as the British Empire in relation to the management of those deemed 'unfit'. As previously mentioned, the Asian 'threat' could not be effectively responded to until the Empire dealt with its own internal threats. One of the major problems was the increasing number of people defined as 'unfit' who were considered to be a threat to both the strength and cohesion of the Empire, and civilisation as a whole (Fleming, 1981). Much of the literature on eugenics was brought in from overseas and so promoted eugenics from an American and European perspective.

Tennant (1996) states that "racial fitness was a dominant motif in social policy during the early twentieth century and it had profound implications for disability" (p. 12). Such theories had a detrimental affect on the way people with intellectual disability were viewed. The government went so far as to quantify the perceived problem the defective people presented through a census.

#### **4.5 Professional and academic interest**

An integral part of a moral panic is professional and academic interests providing credibility, and making the panic 'real'. Fleming (1981) describes a work by a New Zealand born surgeon, W. A. Chapple, who went on to become a politician. The book titled *The Fertility of the Unfit* is described as hair-raising (Searle, 1976 cited in Fleming, 1981). Leading political figures accepted its arguments. Among those was the Chief Justice, Sir Robert Stout (Fleming, 1981). In this work Chapple drew together the strands of "crime, insanity and pauperism" and identified as the cause of those problems, "that society was breeding from 'defective stock'" (p. 12).

Other important issues raised, which articulated the general concerns of eugenicists included: that the 'fit' needed to breed more; that the cost of supporting the 'unfit' be lowered; and that the state play a role in preventing the procreation of the 'unfit'.

Amongst other recommendations made by Chapple was the creation of a board that would issue marriage certificates, but only to the 'fit'. Fleming (1981) asserts that it is difficult to know the extent of the influence of Chapple's work, though he does that New Zealand doctors were still quoting the book twenty years after it's publication.

Eugenics societies that were launched in New Zealand had the support of very prominent people. When the Dunedin society was launched the list of speakers supporting the creation included the chairman of the Otago Hospital Board, two Otago University professors, an Anglican vicar and a doctor. The council that was set up included "three ministers of religion, two university professors and seven doctors" (Fleming, 1981, p. 17).

In Wellington in 1911, another eugenic society was formed. The committee included a number of city mayors, MPs from the government and the opposition parties, medical and academic leaders, the Inspector-General of Mental Hospitals and other civic leaders, including Truby King and Sir Robert Stout (Fleming, 1981).

Fleming (1981) asserts that the Eugenics Education Society of New Zealand "assumed the role of a pressure group" (p. 21). Pressure groups are a very important component in the creation of moral panics. This society, through its own membership affiliates, had access to ministers of the crown and was able to push the eugenics message. Another opportunity was for members of the eugenic societies to use public

forums on other issues to raise the eugenic message. Fleming (1981) cites a meeting, where the then Attorney-General of New Zealand, the Honourable J.G. Findlay (then President of the Eugenic Society), took the opportunity while speaking on urbanisation to discuss the problem of the falling birth rate of the 'fit' and "the steady multiplication of weeds and degenerates" (p. 23).

#### **4.6 Parliamentary involvement**

Though the eugenics movement in the United Kingdom had difficulty recruiting members and supporters from politicians this was not the case in New Zealand. The movement in New Zealand enjoyed a strong relationship with politicians and in the parliamentary debates on the Mental Defectives Bill (1911) the Eugenics Society received much praise with William Massey, later the Prime Minister, identifying with pride his Honorary vice-presidency of the Eugenics Society (Fleming, 1981). This interrelationship between politicians and the eugenics movement allowed the widespread dissemination of the threat of the 'unfit' to be maximised and to result in the threats being taken seriously. The eugenics movement expected the state to provide a legislative response to the threat for it had a history of enacting social legislation (Fleming, 1981).

At this time the two conditions mental illness and intellectual disability was considered as one. In the 1911 Mental Defectives Bill those described as 'mentally defective' included those of unsound mind, mentally infirm, idiots, imbeciles, the feeble-minded, and epileptics. The Attorney General asserted in the Legislative Council that the law could be altered to include moral imbeciles, the dumb and blind, inebriates and the deaf if so desired (Fleming, 1981).



The problems associated with the 'unfit' breeding was reinforced as a result of the First World War. Approximately two thirds of the "recruits for the New Zealand Expeditionary Forces...were rejected as unfit- a sign that the country's pioneering stock had rapidly deteriorated" (Fleming, 1981, p. 33). To those concerned with racial 'fitness' a direct repercussion of the 'fit' dying in the war was that the unfit were left to continue breeding.

Though in reality this had nothing to do with the intellectually disabled they were included as a cause of the problem, and primarily the focus was on the intellectually disabled female. Levels of concern continued to rise and this led to a Committee of Inquiry into Mental Defectives and Sexual Offenders in 1924, and in 1928 to the Mental Defectives Amendment Act. The females were viewed as the main problem because of their propensity for criminal behaviour, prostitution and prolific breeding (Fleming, 1981). However there was also a slowly increasing rate of sexual offending by males which was considered to be an obvious sign of social debasement. This knowledge reinforced the perceived connection between mental deficiency and sexual depravity (Tennant, 1996).

#### **4.7 The authorities response**

In 1920 the Prisons Board passed a resolution based on the problem of mental defectiveness and sexual offending which recommended passing an amendment to the "Crimes Act" so that the 'defectives' could be given indeterminate sentences. Additionally they could be made to undergo medical procedures "either for their own good or the public interest" (Fleming, 1981, p. 37). These recommendations received quite widespread newspaper coverage. Nevertheless, another newspaper article reported the views of an unnamed medical person who advocated

that the rational outcome would be to identify "children displaying hopeless deformity or imbecility" (Fleming, 1981, p. 38) and prevent the continuation of their lives.

Other options discussed and advocated for in the prevention of the further degeneration of New Zealand society included sterilisation of the mentally deficient, having to obtain marriage certificates from medical boards identifying the couple as 'fit' to breed, and sterilisation of sexual offenders. Newspapers thought that such suggestions were ahead of their time (Fleming, 1981). However, though many professional, academic and political people were involved, and were widely reported in the newspapers "the public were, in general, little interested in the issue" (Fleming, 1981, p. 39).

In 1923, the triple concerns about sexual crimes, incipient mental illness and the breeding of the mentally defective prompted the New Zealand Government to establish a committee to examine mental defectives and sexual crimes. The committee comprised many medical, political, justice and health professionals. Many witnesses were called and questionnaires were also sent out. Replies from health professionals clearly called for harsh measures, including segregation, sterilisation and even euthanasia. In line with the overseas pseudo research into families of mentally defective people (Jukes and Kallikaks) 'evidence' was given by a probation officer of corresponding families being present in New Zealand (Fleming, 1981).

The final report was ambiguous. It asserted on one page that through the use of sterilisation and segregation mental defectives could be eliminated from society and on another identified that mental deficiency could never be totally removed (Fleming, 1981). The report was decidedly biased in favour of a eugenics answer, quoting a great deal of

eugenics material in support of the report's findings and reinforcing again the connection between the intellectually disabled and criminal offending.

The decade from 1920 to 1930 saw the highest levels of hysteria about mentally defective people, with the 1924 Committee on Mental Deficiency and Sexual Offending and the 1928 Amendment to the Mental Defectives Act. The Mental Defectives Amendment Bill was introduced and one clause identified a new group, the 'social defective'. The definition of this group was vague but indicated that such a person was antisocial and committed acts, "from cruelty to animals and children, to acts of danger to the community, such as arson- and his crimes are unnecessary and motiveless" (Fleming, 1981, p. 51). The Bill caused considerable debate in Parliament with the main opposition coming from the Labour Party. The debates received wide newspaper coverage.

Notwithstanding the hysteria this period was also a time when many changed their opinions about eugenics. Some began to see eugenics as a pseudo science and believed that psychology was in fact a better answer for dealing with the mentally ill and the intellectually disabled. One, Doctor Moore, had concerns about the 1924 report and stated that the committee "sat at a time when a wave of panic was at its height, influencing not only the public but also professional opinion" (Fleming, 1981, pp. 49-50). Fleming also comments that additional opposition came from academic quarters and from Roman Catholics. The opposition received wide newspaper coverage and at least one newspaper, the Otago Daily Times, ran a series of articles on mental deficiency.

The nineteen thirties saw the practical end of the eugenics panic, although women's groups in New Zealand continued to show a great deal of interest (Fleming, 1981). Factors that are thought to have caused interest to fade include the advent of the Great Depression and international concern about the threat of another war (Fleming, 1981).

The eugenics period was different from any other historical time in respect to persons with intellectual disability and other 'mentally deficient' people. Influential people usurped Darwin's theory of evolution and reshaped it to fit their desired objectives. With a powerful theory on which to base their arguments the supporters of eugenics were able to influence politicians, academics and those who worked with the mentally deficient. The influence was demonstrated in legislation and policy, which had the effect of removing many from the community and resettling them in institutions. It was also the time that perceptions were changed and attitudes hardened with regard to the intellectually disabled. No longer were they simply a burden on society, they were now dangerous and a threat to human improvement.

#### **4.8 Echoes from the past**

There seems to be little doubt that the mentally deficient were, during the eugenics period, considered to be a fundamental threat to society. In terms of a theory of moral panic some features were present. These included a range of interest and pressure groups, a particular style of media coverage, the involvement of professional and academic interests, and particularly strong positions being taken by established authorities including politicians. It may therefore be argued that a moral panic did exist during the eugenics era with regard to people with intellectual disability. Certainly Fleming (1981) and Trent (1994) take this view.

This period should not be seen as a bizarre episode that is better forgotten. Many of the laws and policies that were initiated then still haunt the intellectually disabled today. The policy of segregation and housing them in institutions is not yet a thing of the past. Some people with intellectual disability still reside in large institutions, Kimberley near Levin is one example. Still others live in community houses, which are often in effect mini institutions, for they remain largely segregated from the wider community.

Another echo from the eugenics period is legislation relating to procreation. Remaining on the statute books in slightly different terminology is Section 138 of the Crimes Act 1961, the offence of having sex with a severely sub-normal woman or girl. Its ancestry can be traced back to legislation passed during the eugenics era. Though it is couched in terms of protection for the females it has the effect of preventing children being born to them. Where children have been born to women with intellectual disability a number of the children have been removed. Recent research showed that there are now an increasing number of intellectually disabled women and girls being sterilised. A 1990 court case<sup>7</sup> found that parents of intellectually disabled children did not have to get a court order to have their children sterilised.

The eugenics period left a legacy of pernicious legislation, institutionalisation and treatment of a group of marginalised people. A movement considered dead appears still to influence the thoughts and actions of people who retain control over the lives of the intellectually disabled. Compulsory care legislation appears to be yet one more interpretation of eugenics.

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<sup>7</sup> The Dominion, 15.12.90

#### 4.9 The new eugenics

The question posed here is whether or not eugenics died in the 1930's or has had a continued existence. Information will be examined to show that the philosophy of eugenics continues to exist in different forms.

One of the difficulties for those who believed in the eugenics cause was that after the end of World War Two, there was a general revulsion at what the Nazis had done in the name of eugenics (Kevles, 1985). Yet this revulsion did not stop the renowned geneticist Lionel Penrose, "a world authority in the genetics of mental deficiency", becoming "the Galton Professor of Eugenics at University College", Cambridge (p. 213).

Lerner (1992) discusses the career of Konrad Lorenz, a German biologist. He worked in a field associated with eugenics in Germany during the Nazi period. He continued his work continued after the end of the Second World War and in 1973 was awarded the Nobel Prize for his work. He is quoted by Lerner as saying "I am by inheritance obsessed with eugenics" (p. 51).

During the 1960s and 1970s, with the advancing knowledge of genetics, a number of noted scientists argued for eugenic principles to be applied to social policy. For example Hermann J. Muller, a Nobel Prize winner in the field of genetics, argued for germinal choice. This meant the storing and use of sperm with which to raise the quality of human stock (Kevles, 1985). Some years after his death a sperm bank was set up in his name in the United States with the intention of taking sperm only from Nobel Prize winners. Hardin (1960) describes the use of sperm banks as positive eugenics, where donors are "for convenience' sake, medical interns" (P. 313). Hardin's presumption is that medical students constitute better breeding stock. His argument relates to the

statement made by Charles Galton Darwin, grandson of Charles Darwin, who in 1952 argued that:

This restraint of the breeding of the feeble-minded is important, and it must never be neglected, but it cannot be regarded as a really effective way of improving the human race. If by analogy one wished to improve the breed of racehorses, one might accomplish a little by always slaughtering the horse that finished last in every race, but it would be a much slower process than the actual one of sending the winner to the stud farm (P. 335-336).

In the late 1960s Robert L. Sinsheimer, a distinguished molecular biologist, asserted that a new eugenic era was beginning and that human beings would be able to design their descendants (Kevles, 1985). Another very well known geneticist, Arthur Jensen, argued that he had, through IQ testing, noted a racial difference in intelligence between white and African Americans (Jensen, 1977). Meanwhile in the United Kingdom, Sir Keith Joseph, Minister for Education in the Thatcher government asserted that the poor were leading Britain down the path to degeneracy (Kevles, 1985). In 1971 a leading researcher in genetics, William Shockley, argued that welfare programmes in the United States were creating a degenerative race through the disproportionately high breeding rates and survival rates of the poor, especially African Americans which would result in "genetic enslavement" (Kevles, 1985, p. 271). That meant permanent placement at the lower end of the socio-economic ladder with no chance of advancement.

#### **4.10 Socio-biology**

With the emergence of a new discipline, socio-biology, the new eugenics had arrived. Socio-biology involved the study of the biological basis of social behaviour of all creatures including human beings. Edward O. Wilson, who wrote extensively on this subject in the 1970's believed that the possibility was afforded for building a set of principles upon which to base "a genetics of behavioral evolution" (Kevles, 1985, p. 272).

Wilson believed that a more intense knowledge of human genetics would allow humans to have better social self-control.

Lerner (1992) argued that the basis of eugenics and of "the contemporary 'synthetic' science of sociobiology...are positions shaped at their core by the doctrine of biological determinism". Biological determinism is the conviction that actions are primarily determined by biological factors. The belief in biological determinism asserts that changing environments does not change behaviour. This provides the justification to implement "dehumanising social policies" (p. xix) in order to protect valued behaviours and that "laws curtailing freedom of movement, or rights of property or citizenship, or freedom of marriage might be enacted" (p. xix). He also argued that socio-biology is used to justify and legitimate social hierarchies.

During the 1970s sterilisation was still widely practised on the mentally ill and the intellectually disabled. In a 1975 report to The President's Committee on Mental Retardation the argument was made that little had changed with regard to eugenics as far as the mentally retarded were concerned, except that the language was less derogatory. Some scientists believed that eugenics programmes might in the foreseeable future be enforced through legislation (Kevles, 1985).

However a backlash against expert authority in America occurred, believed to be due primarily to social upheaval caused by the Vietnam War (Kevles, 1985). The backlash included the creation of an opposition to the new eugenics. Yet the increasing use of legalised abortion to end unwanted pregnancies had the effect of pressuring those who were carrying foetuses defined as defective into aborting them. Economic pressure was also brought to bear to abort defective foetuses. The argument put forward was that welfare dollars could be better spent on



existing problems rather than bringing into the world more dependants who would require welfare dollars to maintain them (Kevles, 1985). This pressure was a mixture of positive and negative eugenics. Positive eugenics means supporting increased breeding of the fit. Negative eugenics means preventing the breeding of the unfit. The mixture combined created pressure on fit parents not to have unfit offspring.

It seems that eugenics is not a dead science. Hardin (1960) identifies that thoughts relating to perfecting humankind go back at least as far as Plato. The need to continually improve is seen as important, but perfection, Hardin believes, would be a disaster for that would make human beings less adaptable and more likely to find themselves faced with biological extermination.

Perhaps modern science however, believing that the tools are either ready to hand or nearly so, considers itself capable of producing superior human beings who would not self-destruct. Hardin (1960) questions such ability to so do, by asking who has the ability to choose their descendants? To paraphrase Hardin's use of a quote by Charles Galton Darwin "for his own successor the utmost he could say would be 'I am selecting you in the hope that you may be... better ... than I have been. But I have no idea how you will set about it, since if I had known what I was failing in, I should have set it right myself" (p. 336-337). This may well apply to scientists.

It is perhaps easy to dismiss the period of eugenics as some sort of aberration, to see the activities and beliefs of leaders of the nation and the community as absurd. Yet in 1990 in a court decision in Wellington the judge agreed that the parents of an intellectually disabled girl did not need court approval to have her sterilised. And as previously stated sterilisation of the intellectually disabled has been rising over the last

few years. And in a comment that reflects eugenic thinking a front-page article in the New Zealand Herald<sup>8</sup> reported the President of the ACT political party advocating a 'warrant of fitness for parenthood'. The same article mentioned the Plunket Society as the organisation that could provide such warrants. The Plunket Society was created on the eugenic assumption that this nation's human stock was degenerating. It was led by a prominent member of New Zealand's' eugenics movement, Sir Truby King.

#### **4.11 Conclusion**

This chapter has discussed eugenics principles and the pervasive influence that it has had on scientific thought from the end of the 19th century until the present day. The eugenic era is considered by Fleming (1981) and Trent (1994) to resemble a moral panic. Evidence has been produced to justify an argument that a moral panic did occur during that period. Many people with intellectual disability were segregated, institutionalised and sterilised during the eugenics era. In a moral panic the panic recedes after intervention of the authorities. The question that now presents itself is does the compulsory care legislation reflect a new moral panic.

Chapter five will describe the process of creating legislation for a small number of people with intellectual disability. It will bring to view data to show that a major concern for government recently has been the process known as deinstitutionalisation, a process driven by the philosophy of 'normalisation'. That philosophy not only drove the process but also underpinned international covenants dealing with the rights of the intellectually disabled to live lives as near as possible to the norm.

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<sup>8</sup> The New Zealand Herald, 14.9.96.

Hardin (1960) states "having eliminated all other enemies, man is his own worst enemy. Having disposed of his predators, man preys on himself" and he asks the question, "how is man to control his own evolution, how can he possibly have the wisdom to do so?" (p. 337). In this chapter eugenics has been equated with genetics. There have been changes in terminology and a softening of the language but the dream of creating superman appears to remain locked in the human consciousness.

## **Chapter Five**

### **Compulsory Care Legislation**

#### **5.1 Introduction**

Chapter five will be extremely detailed. In order to help the reader through the data, a quick synopsis of the main events is provided in an overall historical framework so the reader doesn't get lost in details.

This chapter will review the period of time between the introduction of the 1992 Mental Health (Compulsory Assessment and Treatment) Act and the introduction of the Intellectual Disability (Compulsory Care) Bill into parliament on 5 October 1999. In outline the process of bringing to parliament stand-alone legislation began in 1992 with the passing of new mental health legislation that removed the option of finding intellectually disabled people mentally disordered. 1993 saw difficulties for the judiciary in the disposition of such people and the media picked up on the difficulties. In 1994 an amendment to the mental health legislation was proposed that would reinstate intellectual disability as grounds for mental disorder. That amendment was lost in 1995 and the government then decided upon stand-alone legislation. That process began in 1996. The date for introduction to parliament was deferred on numerous occasions, but finally went to parliament on 5 October 1999 and had its second reading in parliament under urgency a day later.

This chapter will also note and examine the roles of key participants who were involved in the process of the legislation. They included representatives of government and other authorities centred at the Ministry of Health, Ministers of the Crown and members of the

judiciary. Other interested parties or groups included the media, represented primarily through the press, family members of the people who may be subject to the legislation, human service organisations, and professional and academic groups.

## **5.2 How it started**

In 1992 new mental health legislation was passed. The major changes from the previous 1969 mental health legislation was the exclusion of intellectual disability as grounds for being found 'mentally disordered'. This is the finding that allows a person to be held in a mental institution for treatment. Due to this exclusion people with intellectual disability had to be treated as though they were fully capable of taking part in court proceedings. A number of court cases in 1993 brought to the attention of courts that intellectually disabled offenders were not fully capable of taking part in court proceedings. In some cases the judges made comment about the difficulty of dealing with intellectually disabled offenders.<sup>9</sup>

Both the new Mental Health Act and the Criminal Justice Act 1985 were used in unintended ways to persuade the courts that intellectually disabled people were unable to understand what was occurring during their trials. This lack of understanding included being unable to adequately instruct a lawyer or challenge a witness that had spoken against them in the matter.

The researcher's review of the Ministry of Health files on the development of the compulsory care legislation indicates clearly that the problem of treatment and legal disposition of the intellectually disabled was identified in September 1992. This was two months before the

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<sup>9</sup> Court reports of Judge McElrea, March 1993, Judge Moore, July 1993, Judge Boshier September 1993.

introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992. Just prior to the introduction of the new act concerns were raised by at least two Medical Superintendents of psychopaedic or psychiatric institutions. They were concerns about 'treatment without (legal) authority'<sup>10</sup>. The Medical Superintendent at Kimberley Hospital identified a small number of people who were formal patients while the rest were informal. The informal patients were considered unable to give 'informed consent' to the treatment they were then receiving and few had either guardians or family who could give consent for them. Yet without their own or substituted consent the institution providing the treatment was leaving itself open to legal challenge regarding their right to 'hold' these people in institutions. Due to the impending mental health legislation the Superintendents raised these concerns.

A Ministry of Health (MOH) internal memo dated 10 September 1992 raised the same issues as a result of a query that had come from the Medical Superintendent at Cherry Farm Hospital. This memo raised concerns about the continued treatment of people with intellectual disability because of the new Mental Health Act. It stated, "The effect of this (new act) could be to seriously limit the options available for the placement and rehabilitation of such individuals". The difficulties that were causing this concern involved the legal right to treat intellectually disabled patients when the new mental health legislation removed intellectual disability as grounds for being found 'mentally disordered'. The issue of 'treatment' was very controversial as it often implied the use of restraint, both physically and in relation to the use of psychotropic drugs, and detaining people in locked rooms as a form of seclusion.

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On 22 September 1992 the Director of Mental Health at MOH in an internal memo asked the Ministries legal services department to give an “urgent opinion on the issues raised in ... (the Kimberley letter) ... and ... advice about an appropriate response. The issues are not confined to Kimberley; they probably arise in relation to other psychopaedic hospitals as well”. The memo went on to state “I understand that some of these patients are in locked wards, as otherwise they would wander off, at risk to themselves. Some of them also have to be coerced to take medication”.

The director made the point that even under the previous mental health legislation there had been no good grounds to detain informal patients. He stated “The proper care of these patients does constitute a major problem even under the present Act (1969 Mental Health Act).” The Director then viewed other legal options for treatment. “The appointment of guardians under the Protection of Personal and Property Rights Act 1988 or under the Children, Young Persons & Their Families Act (if they are minors) seems to be the proper way to go in such cases. The Courts cannot, however, process 400 applications within 5 weeks!”

The legal services department of the MOH responded on the 28 September 1992, advising the Director of Mental Health that informal patients could decline treatment and leave the hospital if they so wished. Further, the memo identified problems with treating a person who did not wish to be treated. Section 11 of the New Zealand Bill of Rights Act was identified as a protection for people from medical treatment they did not wish to undergo. Criminal sanctions were also identified, as were civil actions against hospital staff. The memo then went into an extended list of previous legal cases that had provided justification for continued treatment. At the close of the memo it argued

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<sup>10</sup> Letter to the Director of Mental Health Division 3-9-92.

that it “may be possible to convince a High Court Judge to exercise the High Court’s inherent “jurisdiction and control over the persons and estates of idiots...” referring to the 1908 Judicature Act. It appears that a major issue here was the lack of legal power available to the courts and hospitals for the control of people with intellectual disability who posed a problem of disposition.

Headlines in the press suggest a range of possible public perceptions. In August and September of 1992, just prior to the passing of the new mental health legislation, a number of articles appeared in newspapers concerning physical attacks on IHC (Intellectually Handicapped Children’s) staff by the people in their care. Headlines at the time included, “Attacks by patients ignored-IHC staff”<sup>11</sup> in the Dominion, and in the same paper a few days later “Community care blamed for IHC violence”,<sup>12</sup> while the Evening Post on 2 September 1992 headlines a story “Spotlight on IHC violence”.

In the second Dominion article some family members of intellectually disabled people argued that the deinstitutionalisation process had brought out into the community people that needed the asylum of institutional care.

On 27 October 1992 the Director of Mental Health Division, MOH responded to the Medical Superintendent at Kimberley, outlining the legal services discussion. This eight-page letter was also circulated to the Manawatu-Wanganui Area Health Board, the local Mental Health District Inspector and the Department of Justice for their information. The letter outlined not only the legal difficulties that would be encountered when the new mental health legislation was passed but also highlighted the misconceptions that hospital management were

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<sup>11</sup> The Dominion, 31.8.92 p.3.



presently under in believing that present legislation gave them a legal right to 'treat' the intellectually disabled people in their care who were classed as informal patients. It did not.

### **5.3 1993**

During the early part of 1993 the Ministry of Health produced a draft of a Project Brief, which had the title 'Service needs of people with an intellectual disability with challenging behaviour'<sup>13</sup>. The responsibility for carrying out the project was given to Regional Health Authorities. The task was to calculate the number of people, in two health regions, that fitted into the category of intellectually disabled with associated challenging behaviours and to discover their service needs.

Two parts of the communication are of particular note and may give an early inkling of the direction that would eventually be taken by the Ministry. One is the identification of 'deinstitutionalisation' as a concern for family members of people who have intellectual disability and challenging behaviours. The other is the 'common responses to challenging behaviours' acknowledged in the letter as already in use. These covered physical and pharmacological restraints, clinical interventions and psychological therapies. Also included were ecological adaptation, behaviour modification programmes, gentle teaching methods and communication based interventions.

Added to this list was the comment that the "administration of psychotropic drugs to 'manage' difficult behaviour in service settings is common, often over many years". As many of the 'common responses' were unlawful in light of human rights legislation, to continue such

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<sup>12</sup> The Dominion, 1.9.92 p. 2.

<sup>13</sup> Ministry of health files.

practices would require other legislation to counteract 'rights' legislation.

### **5.3.1 Pressures**

In May 1993 a MOH confidential draft identified that the Minister of Health was seeking "an urgent report from the Director of Mental Health"<sup>14</sup>, concerning two intellectually disabled people who had been released from Lake Alice Hospital after the new mental health legislation had been passed in November 1992. One subsequently committed a serious crime. Both were considered "to present a high risk of re-offending". The paper discussed, for the first time, "The need for a legal framework for providing care", which translated means the ability to apply compulsion. A number of events concerning intellectually disabled people had been reported in the press during the early part of 1993 and could have acted as a spur for the 'urgent report'.

### **5.3.2 Judicial pressure**

On 26 March 1993 Judge McElrea in one case observed that the position in law of the intellectually disabled was 'particularly unclear'<sup>15</sup>. A psychiatrist in the case reportedly described the offender as "a danger to the community", because of his seriously irresponsible behaviour. The judge also accepted hearsay evidence for the purpose of identifying the potential risk posed by the person.

On 2 July 1993 Judge Moore, in the Otahuhu District Court, made comment in a case of arson in relation to a man with intellectual disability. The judge stated "this case highlights a very real problem both for the courts and for people who are able to cope in the

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<sup>14</sup> Issues concerning the management of people who offend, and who have an intellectual handicap or a personality disorder, undated.

community but only just. They have the same rights as everyone else but equally they are subject to the same laws... (a clinical psychologist) ... equated (defendant's name), in some ways, but not by any means totally, with a five year old youngster...I am satisfied on the totality of the evidence before me that he would have been a competent witness"<sup>16</sup>.

And in September 1993 in another case in the Auckland District Court a judge discussed two other relevant and recent cases where there was a difficulty in deciding how to deal with of an offender with intellectual disability. He then made a controversial<sup>17</sup> decision, which in a later case he informed the court had caused him "to be burnt".

These cases represented fairly typical concerns of judges who had no specific legislative options open to them if they wanted to take into account the person's disability.

### **5.3.3 Media pressures**

Running concurrently with the court cases were the media reports of those and other cases. Early in 1993 an article headlined "Client who ran amok with a hatchet revives IHC safety fears"<sup>18</sup> recreated the concern that had been raised the previous year. The article used language that could be considered extremely emotive. "The IHC client hacked 67 gouges out of wooden lockers... IHC staff were absolutely beside themselves".

Later that year a report about the rising tide of crime under a front page heading "Violence flares around country"<sup>19</sup> was published. This was an

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<sup>15</sup> Queen v. T.

<sup>16</sup> Queen v. Asapha Junior Haurua. T. 736/93

<sup>17</sup> Personal communication

<sup>18</sup> The Dominion, 24.3.93 p. 3.

<sup>19</sup> The Evening Post, 2.10.93 p. 1.

article concerning the general rise in crime levels. Included in the story and taking up almost a fifth of the article was the story of an assault by a person with intellectual disability who was the resident of "an IHC hostel".

In The New Zealand Herald, dated 22 September 1993 a story ran that appeared to concern Ministers of the Crown. Titled "Childlike man must stay in jail", the story included many of the ingredients of the stereotypical 'dangerous' intellectually disabled person. The first paragraph read "the imprisonment of an intellectually handicapped man may prompt cabinet ministers to consider establishing a special institution to handle such cases". The article stated that the case had gone to the Court of Appeal, which had upheld a sentence of 4 years for arson. The judge stated that "there was a deplorable absence of suitable custodial institutions for the care of intellectually and socially disabled offenders". The defendant was described as having the mental level of a five-year-old child. The report mentioned that a residential service had been offered but the Court had turned it down because "unconditional supervision could not be guaranteed and it had been acknowledged that there were risks to the community if (he) stayed there". The article reported that the Minister of Justice believed the time was right to look "at something that is not the same environment as the prison but is secure, has an element of punishment but is more fitting with such a situation". The Minister of Justice was understood to be making contact with the Ministers of Social Welfare and Health to look at the problem. In this newspaper report the statement, "noting that (his) next fire might result in loss of life" identified the potentially dangerous nature that appeared to be ascribed to the intellectually disabled and which caused so much discussion in Ministry files relating to issues of human rights. This is the dilemma of the permissibility of

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detaining a person on the grounds of their potential dangerousness. Lastly an unnamed psychologist was reported to have said that the man was quite happy to serve a prison sentence as the guards looked after him.

#### **5.3.4 Ministry of Health activities**

On 4 June 1993 there was a MOH meeting to identify what actions could be taken to meet the needs of the small group of people with intellectual disability that required compulsory care. Those attending included the Director of Mental Health, the Manager of Disability Support Services and two staff members of MOH. Options, primarily legal, were examined. These included the creation of new law and the amending of existing legislation, i.e. The Mental Health Act. Of significance was the observation that new legislation would be considered unfavourably by 'the disability sector' especially for a small group of people<sup>20</sup>.

In a MOH internal memo, dated 31 August 1993, which discussed the 'provision of services for people with intellectual disability who have allegedly committed crimes', the writer reiterated points originally drafted for the minister with responsibility for disability issues. The notion of public safety was identified. Also mentioned was that people identified as having an intellectual disability and who offended were those who "have a history of not being adequately cared for by existing services" (p. 2). Another point clearly enunciated was that the "public view of mentally ill offenders is exaggerated and fearful. The public are unlikely to discriminate between people who are mentally ill and offend, and those who are intellectually disabled and commit offences" (p. 3).

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<sup>20</sup> Notes of a meeting to discuss intellectual disability compulsory care.

### 5.3.5 Working Group

In a letter written to John Dawson at the Faculty of Law, University of Otago, dated September 1993, the Director of Mental Health<sup>21</sup> mentioned that issues, unspecified in the letter, had arisen since the introduction of the 1992 Mental Health (Compulsory Assessment and Treatment) Act. Also mentioned was the formation of a “small working group to consider legal issues surrounding the care and treatment of individuals with intellectual disability, who are unable to give consent...(and)...the needs of intellectually disabled offenders”.

In October a Working Group meeting was called by MOH to ‘discuss issues related to intellectual disability and compulsory care’<sup>22</sup>. The meeting included many high-ranking mental health and intellectual disability professionals and high-level ministry officials. The meeting reviewed the situation regarding two groups of intellectually disabled people, those who committed criminal offences and those who because of challenging behaviour posed problems for their caregivers. At that meeting the issue of restraint, locked doors and seclusion<sup>23</sup> was discussed. The meeting then went on to identify the main problem as service provision with the participants agreeing however that a regulatory mechanism was needed to enable services to provide ‘compulsory care’. Areas of concern identified included management plans and a lack of trained staff. Six years later these concerns have not yet been addressed.<sup>24</sup> A report of that meeting suggested in the ‘recommendations & actions’ section that a meeting with officials of the Justice Department and Police was planned to find out how many people might come within the orbit of the legislation and to identify training issues.

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<sup>21</sup> Dated 22.9.93.

<sup>22</sup> Dated 14.10.93, hosted by MOH

<sup>23</sup> Seclusion entails locking the person in a room until they quieten down.

There followed from that meeting a report to the Parliamentary Social Services Select Committee, outlining procedures taken before the change in mental health legislation. "In the past people with intellectual disabilities who offended or posed a risk of offending, but did not go through the criminal justice system, often were placed in (named) institutions. Their behaviours were contained with medication and restraint, with little emphasis on habilitating the person"<sup>25</sup>. This report outlined the concerns of service providers in the different regions. One concern raised was the likelihood of a 'hidden population' of mildly intellectually disabled people who posed a probable risk of offending.

In a report by John Dawson, dated October 1993, to the Ministry of Health's Working Group on Secure Provision for Intellectually Handicapped Offenders he defined the issues that the working group would face. The report mentioned remarks made in the High Court and the Court of Appeal that "show that members of the judiciary believe some form of specialist service should be available to provide custodial care for a small group of IH offenders who commit serious criminal offences". One case was cited where the Judge "referred to 'the deplorable absence of any suitable custodial institutions for the care of intellectually handicapped and socially deviant offenders'<sup>26</sup>".

An observation made in that report was that the service issues had to be resolved before the legal issues were addressed. "Addressing the legal issues first is to approach the problem back to front and will not produce a satisfactory long term solution" (p. 2). Further discussion in the report supported this statement. In considering 'The Victorian Intellectually Disabled Person's Services Act 1986' Dawson stated "here

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<sup>24</sup> Personal knowledge and involvement in a particular criminal case.

<sup>25</sup> Report titled 'Existing services for people with intellectual disabilities with challenging behaviours'.

<sup>26</sup> Justice Casey in R v Arama.

is an example close at hand of a fully fledged 'third' system for the legal control of the anti-social IH person" (p. 3). Dawson also included another criminal case of a man with intellectual disability who was causing the judicial system difficulties. In regard to this case there was discussion of reports on the man's 'dangerousness' and his 'danger to the community'. It should be noted that terms relating to 'dangerousness' had been included in Ministry of Health files from 1992 onwards.

Dawson advised the 'Working Group' not to take easy solutions by changing present law to fit people with intellectual disability into it. He said that would "simply take us back to the bad old days when IH people were warehoused in the back wards of psychiatric hospitals in poor conditions with high rates of mortality" (pp. 11-12). The report then argued that "the right place for the education and habilitation of IH people" was not psychiatric hospitals. Further he argued that "unlike medication, educational services cannot be provided on a compulsory basis, except perhaps in special facilities with trained staff" (p. 12).

The government appears to have ignored Dawson's advice and an amendment to legislation was proposed that would have reinstated the intellectually disabled into legislation from which they had been specifically excluded. That is, The Mental Health (Compulsory Assessment and Treatment) Act 1992. Such a move would have allowed people with intellectual disability who committed offences to be found mentally disordered by the criminal courts and made special patients, thereby allowing for their detention in a hospital.

In November 1993 a conference held in Dunedin on intellectual disability included discussion about people with intellectual disability and criminal offending and attracted overseas speakers, one of whom



was subsequently contacted by the Ministry of Health for information on this topic.

By December 1993 a MOH internal memo titled 'Intellectual Disability & Compulsory Care' indicated that a census of people who might come within the orbit of special legislation was being undertaken. The memo also stated that judges around the country were concerned and that at a meeting held with Family and District Court Judges it had been suggested by the judges that the intellectually disabled be put back into mental health legislation using an amendment to the 1992 Mental Health Act. The memo made reference to the Minister of Health, who viewed the matter as urgent.

It appears that the MOH was heeding the concerns of judges around the country and preparing to reinstate intellectual disability as grounds for being found 'mentally disordered' the term used to stop criminal court proceedings in favour of a mental health approach to the defendant.

To summarise, 1993 had the release of people with intellectual disability who were deemed dangerous. This had brought pressure on the government from both the media and more importantly the judiciary who wanted a disposition option. The Ministry of Health had responded first by making contact with outside experts in law and in the field of intellectual disability and secondly in taking the decision to respond through legislation.

#### **5.4 1994**

On 26 January 1994 a media statement was released from the offices of the Attorney-General, the Minister of Health and the Minister of Justice, prompted by concerns raised in the press regarding an intellectually

disabled man released from psychiatric care after the change in mental health legislation. In part it stated "Caucus and Cabinet are committed to making progress on this serious issue". Attached to the media statement in the Ministry file is a newspaper clipping running the story. Also attached to the media release is a directive from the Minister of Health for a review of existing services and law relating to intellectually disabled offenders, principally sexual offenders. A memorandum for Cabinet also dated January 1994 asserted that the case had highlighted many issues and an in-depth review was recommended.

In February 1994 a Report by the Auckland District Law Society entitled 'Special Patients' was published. Part of the paper discussed people who were found 'unfit to plead', that is, not fit to take part in a court case by reason of an inability to understand the processes of the court. The report stated " in a real sense the difficulty with offenders under disability or unfit to plead is not in making the determination so much as in deciding what to do with such persons once that determination has been found" (p 10).

#### **5.4.1 Media connection**

In early 1994 the press had written quite extensively about people who had intellectual disability and were either presumed dangerous or involved in criminal activity.

The Evening Post in a full-page article titled "All messed up and nowhere to go"<sup>27</sup>, described the difficulties of finding appropriate services for people with intellectual disability that committed offences. A point worth noting in the article is the denial by the then Chief Executive Officer of IHC that the two men described in the story were in

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<sup>27</sup> The Evening Post, 26.1.94

fact intellectually disabled even though one had previously been a client of that organisation.

Early in 1994 an article appeared relating to an audit of “potentially dangerous patients” who had been released because of the passing of the 1992 Mental Health Act. The story identified one man with intellectual disability who “expressed sadistic sexual fantasies”... and was... “told to stop hanging around a primary school”<sup>28</sup>.

Also in early 1994 a headline in The New Zealand Herald proclaimed, “‘Draconian’ laws planned by Shipley”<sup>29</sup>. The story discussed a “potentially dangerous mental patient ... at large in the community”. The story also identified the problems associated with the new mental health legislation where numbers of people who were considered “very, very serious offenders” had been released because of that legislation. The article went on to state that “Mrs Shipley said the Government planned to put all three groups on the same footing in the legislation now being drafted”. The three groups referred to were the mentally ill, the intellectually disabled and those with personality disorders. The story told of two recently released patients who had perpetrated sexual assaults.

This article was confusing for the readers by creating the notion that the different groups of people were all the same and would be treated the same. Such confusion about mental illness and intellectual disability was identified as problematic in the MOH files.

Another example of this same confusion arose in an undated newspaper article where “A High Court Judge said yesterday that he saw no prospect of it ever being safe to give a convicted paedophile his liberty.

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<sup>28</sup> The New Zealand Herald, 3.2.94

The defendant “was one of the 37 psychiatric patients released...(through a) loophole in the law...(He) had been released and was for some time unsupervised... although (he) had committed similar offences. Though 37 years old he had the mental age nearer that of his victims, age five” (Appendix B).

In February 1994 the MOH sent the Minister of Health, an estimate of the number of people who had been discharged from compulsory treatment because of the mental health law change. The estimate ranged from 32 to 42. In the report the Director of Mental Health Services at Templeton Hospital, discussed the dangerous intellectually handicapped. He stated, “The staff at Templeton Centre are committed to continue to provide asylum and safety for these people, ensuring that a catastrophe does not occur and the risk of imprisonment with the attendant damage to severely disabled people is averted”.

The Dominion ran a front-page story on 4 February 1994 headlined “Nurse tells of rape, plot to kill”. The story highlighted the dangerousness of an intellectually disabled man and the meagreness of service support provided when he was released into the community. In a North and South article McLeod (1994, 80) stated:

we used to call them sociopaths: now we say they have “personality disorders”. Some are intellectually handicapped as well, their low intelligence putting them even further beyond help or conscience. These were 11 of the men on Shipley’s list of 35...eight were intellectually handicapped and dangerous.

#### **5.4.2 The Mental Health Amendment**

The newspaper reports and the release of dangerous people were followed quickly by governmental response in the form of legislation.

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<sup>29</sup> The New Zealand Herald, 1.3.94.

Creating new law requires a great deal of time and planning. An amendment to existing law provides a quicker solution.

The first attempt to create a legal mechanism with which to control intellectually disabled offenders was by passing an amendment to the 1992 mental health legislation. However there was some opposition to the Minister of Health's plan to amend the mental health legislation. Under the heading "Shipley scheme rejected", an article in *The New Zealand Herald* on 3 March 1994 reported that "more opposition is emerging to the plan by the minister of health to link intellectually handicapped people to measures to control the release of dangerous mental patients". In another newspaper item in March the Mental Health Foundation, warned against hasty law change with regard to people with intellectual disability who have challenging behaviour and constitute a "risk to society"<sup>30</sup>.

In March 1994 a memorandum from the Executive Assistant to the Minister of Health to the Minister of Health warned the Minister that the disability sector had concerns about an amendment to the Mental Health Act 1992 and believed that the amendment would constitute a return to medicalising disability.

Newspapers also covered other aspects of this controversy. In *The Dominion* on 31 August 1994 the Headline read "Law for dangerous handicapped sought". The story related to the findings of the NZ Law Commission in their report 30. This article began with a paragraph on people with intellectual disability but the main content regarded people with mental health problems. The headline gave a very distorted idea of the story. The confusion between mental illness and intellectual disability was further highlighted.

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<sup>30</sup> Mental Health Foundation 2.3.94

On 23 August 1994 the New Zealand Law Commission's report on 'Community Safety: Mental Health and Criminal Justice Issues' was released by the Minister of Health, who stated that "the terms of reference were precipitated by the serious offending of a former psychiatric patient and the resulting public concern. Shortly afterwards another former patient committed serious offences"<sup>31</sup>. As is shown by the title the blurring of boundaries between mental health and intellectual disability occurs at the highest levels. Much of this report concerns people with intellectual disability. A second point of interest not raised as an issue in the report but obvious from the statement is the way in which a major controversy can be fuelled by one instance. In this case one former psychiatric patient and their actions are described without any contextualising information.

#### **5.4.3 New Zealand Law Commission Report 30. Community Safety: Mental Health and Criminal Justice Issues.**

A number of issues were raised in this report. One was that the short time the Commission was allowed for "fact -gathering and consultation", because of time constraints.

In the overview to the report the Law Commission discussed "two critical values" (p. 1). These were the right of the community to be protected from physical harm administered by other people and the rights of persons not to be arbitrarily detained by the state or to have their freedom restricted without good justification. It continued by stating that "ideally, out of that conflict of principles and values should come law consisting of wise restraints that make us free" (ibid). The overview explained that to detain persons without conflicting with the

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<sup>31</sup> NZLC Report No. 30.

New Zealand Bill of Rights Act 1990 detention must be “demonstrably necessary” (ibid). The overview also cautioned against the over use of detention as it may have a different impact on differing sectors of society.

Report 30 cautioned that law change would provide only a part of the necessary changes, and that adequate resourcing supports both in the community and in institutions were crucial factors. The Commission also reminded the reader that the report should be viewed in context with the move to community care.

In a background section the report raised the issue that detention must not be arbitrary. That it must be able to be justified in relation to the reasons given. Therefore if the detention is to protect the public from people who have an intellectual disability and who are deemed dangerous then that must be justifiable in “a free and democratic society” (p. 2).

The report also raised the issue of potential dangerousness and argued that predictions of dangerousness have an accuracy rate of 50%.

The issue of detention based primarily on disability was mentioned in regard to the prohibition of discrimination. It declared that detained persons must not be “subjected to cruel, degrading or disproportionately severe treatment or punishment. As well, everyone had the right to refuse to undergo medical treatment, although certain compulsory treatment might be able to be justified” P. 3).

On page five of the report the Commission proposed that new legislation be prepared to deal with the problem of people who have intellectual disability and who either offend or are dangerous to the community.

Here is the first mention of stand-alone legislation. Another first is that though not described as 'offender group' and 'civil population', the report wished to include those who had not committed any offence. Seesaw activities occurred in the ministry in relation to the inclusion of the civil population into the legislation. The decision was not finalised until late 1997. Yet this report three years earlier gave an indication of the shape the final decision would take. This document provided the outline of the final legislative draft. In the same paragraph the report mentioned that reviews of compulsory care orders should be more widely spaced, "in recognition of the more durable nature of the condition" (p. 5). The statement obviously confused intellectual disability, the condition, with dangerousness, the behaviour. The condition is durable. The behaviour not necessarily so. And, this assumption followed through to the legislation. It may be presumed therefore that this report had a strong impact on the direction and outcome of the deliberations regarding compulsory care.

On 16 November 1994, a page three article appeared in *The Dominion* stating "Templeton to close-CHE". The main thrust of this account was that 75 patients being released needed secure and specialist supports. And, on 7 December of that year in *The Dominion* was an article about a 17 year-old man with intellectual disability who had pleaded guilty to assault charges. Three months previously on similar charges the man had been found 'unfit to plead', that means unable to go through the court process because of his inability to understand the processes of the criminal court. In this particular case the service agency had refused to have the man back because it was unable to cope with him. Other service providers declined to provide a service. The refusal on the part of services to accept the man heightened the problem of 'management' of those deemed dangerous.



Notwithstanding opposition from many disability sectors the plan to amend the law continued until it had been introduced to Parliament and then referred to a Parliamentary Select Committee, where opposition to the amendment was sufficient to prevent the Bill's progress.

#### **5.4.4 Project 17233 Compulsory Care**

In August 1994 an internal memo at MOH outlined proposed legislation to deal with the issue of compulsory care. In outlining why the draft project proposal had been prepared the author wrote to "demonstrate to the Social Services Select Committee that the Ministry is undertaking some work in an area to the Bill they are currently considering, suggesting ... a course of action they may wish to follow"<sup>32</sup>.

In that draft document "Project 17233" there was the first MOH mention of legislation going beyond dealing only with criminal offenders with intellectual disability and "including those who have never been brought to the attention of the police or criminal justice system". This group of people came to be known as the 'civil population'. They are those people who are deemed dangerous either to themselves or to others, but have not been charged with a criminal offence. This group was first mentioned in the Law Commission's Report 30 and had obviously been picked up on quickly by the Ministry of Health. This should not be a surprise for the initial concerns that were received by the ministry came from the Superintendents of large institutions whose concerns centred on the treatment of the informal inmates. That is those who had not been charged with crimes but were difficult to treat. In other words the civil population. The MOH report discussed 'restraint' and how it was used in "hospitals, in rest homes and in

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<sup>32</sup> Dated 11.8.94.

supported residential accommodation funded by the Government". It stated "ironically, research findings tend to indicate that in many cases challenging behaviours are a result of restrictive and unstimulating environments". Though not specifying stand-alone legislation the documents appeared to widen the government's possible options.

On 12 August 1994 a facsimile was sent to the CEO of Spectrum Care Trust<sup>33</sup> from the Ministry of Health, asking for a description of the type of services that Spectrum Care provided for people who posed a risk of offending. His response<sup>34</sup> outlined the problems caused by intellectually disabled people with challenging behaviour or who committed criminal offences. The letter made the point, previously made in correspondence, that those with challenging behaviours did not need restrictive environments, but that judges "need to feel that they are going to be living in a supervised setting which can preclude re-offending". The letter also identified some of the people as "a major threat to the community in terms of aberrant sexual and aggressive behaviour"<sup>35</sup>. The letter then identified a proposed "structured living environment which will contain this group". It should be noted that this particular service was not able to cope with the people that it placed in the setting. Six months after the service began the first contained person went back to court for criminal offending. Subsequently all of the original people sent there were back within forensic services (lock up mental health services)<sup>36</sup>.

On 15 August 1994 a facsimile was sent from Southern Regional Health Authority to the MOH with information for the Select Committee on Social Services that was then considering the Compulsory Care issue in the Mental Health Amendment Act. It informed the Ministry that

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<sup>33</sup> A large and expanding human service provider

<sup>34</sup> Service provider for people with intellectual disability

<sup>35</sup> Letter dated 16.8.94.

anyone residing in their region who posed a risk of offending was still being held in Wakari, Templeton or Seaview Hospitals. This information would certainly be problematic for the MOH in view of the continuing deinstitutionalisation of intellectually disabled people.

A draft agenda for a workshop to discuss the scope and nature of legislation relating to intellectually disabled “offenders” was circulated in a MOH internal memo on 12 September 1994. The stated purpose of the workshop was to get the legislation under way. Though not specified it is pertinent to suggest that the Law Commission’s Report had steered the Ministry away from a law amendment to stand-alone legislation and that this workshop would adopt that course.

A meeting was held at the MOH on 28 November 1994. Those attending included Ministry officials; CEO’s of Human Services, High level managers within human services, a Director of Area Mental Health and a mental health District Inspector. The purpose of the meeting as outlined “was to identify the scope and nature of a framework for the disposition and care of offenders with intellectual disability and for individuals with intellectual disability who are considered to present a significant risk to other people”. This purpose was “met with some concern from those present” as they felt that there were other important issues to address. However a senior representative of the Ministry, in discussing the need for new legislation, referred to the report put out by the Law Commission on Mental Health and Community Safety. “He advised that it is likely that there will be a directive that such legislation be developed”.

At the end of 1994 the Law Commission Report 30 appears to have had the effect of moving the MOH from its position of adding an amendment

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<sup>36</sup> Personal knowledge

to existing legislation to preparing stand-alone legislation. The media had been given the opportunity by at least one ex-patient to create a high level of concern. Whether that concern reached down as far as the public is not known, but it did reach the government and the government reacted to it first by initiating the Law Commission's investigation and then by adopting its recommendations.

## **5.5 1995**

Early in 1995 two separate newspaper reports identified that another hospital where intellectually disabled people were being held would close and that 200 patients would return to the community. In one of the articles reference was made to people who might pose "a risk to themselves or others".<sup>37</sup>

The two articles were followed up on 8 March 1995 by an editorial in *The Evening Post* that revealed 200 mental patients would be returned to the community. It claimed that, "The latest round of the ejection strategy is being done in the name of saving money". It added, "these changes are for financial reasons, not medical ones". The "Post" also added to confusion by bringing the mentally ill and the intellectually disabled together as though they were one homogeneous group. The editorial might have helped fan panic thinking when it stated "In Britain there have been killings by mental patients deemed ready for release". The editorial caused a question in Parliament to be raised about security of funding for the patients to be released. Security of funding refers to the guarantee of long term financial support needed for the people who were to be moved out of institutions and placed into the community.

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<sup>37</sup> *Evening Post*, 6.3.95 page 1. Other article *The Dominion* 7.3.95.

Just a day or so before these two articles appeared another item in the Sunday Star-Times<sup>38</sup> reported on workplace violence. Although this was a general story two examples were given of people with intellectual disability assaulting staff in 'workshops' (day centres for people with intellectual disability).

Taking a different approach was a page two story in the Evening Post on July 4, 1995. In this book on 'rights' for intellectually disabled people the author discussed Kimberley Centre saying, "there were all these people there that didn't seem to be taking part in the world".

The Listener magazine in October 1995 picked up on the problems for service providers with an article concerning a new solution for "dangerous patients". The front cover stated "Exclusive: Dangerous patients- a new solution", while inside the report talked about no locks and no bars. This account related to the 'structured living environment' set up by a service provider, mentioned previously in this chapter, which was intended to preclude re-offending<sup>39</sup>.

In December of 1995 a number of newspaper reports<sup>40</sup> ran various accounts of problems associated with the care of people with intellectual disability. Two articles in separate issues of The New Zealand Herald on the 6<sup>th</sup> and 7<sup>th</sup> highlighted problems for courts when services would not take back the person in their care after the person had appeared in court on criminal charges. One headline read "Man's 'cruel punishment' puts care trust in dock". The point was made that the man was in prison because the service would not take him back. The Chief Executive Officer of the trust was quoted as saying "there are wider issues of care and protection that clearly come into play. We have

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<sup>38</sup> Dated 5.3.95. Headline "Tackling violence in the workplace".

<sup>39</sup> Dated 21-27.10.95

<sup>40</sup> The New Zealand Herald 6.12.95; The New Zealand Herald 7.12.95

got to protect the public as much as care for the individuals". It should be noted that in this case the person with intellectual disability was one of the men housed in a setting that was intended to preclude offending. Clearly from the statement made previously the service had failed to either "contain this group" or "preclude re-offending".

The second New Zealand Herald report highlighted two separate cases. Both indicated that the judges were very concerned about the problems associated with care for people with intellectual disability. Neither of the men in the two cases had anywhere to live. One man was sent to prison while the other was simply released by the court.

A story in the Evening Post<sup>41</sup> identified that a man with intellectual disability had set fires in the Wellington region while another story in the Wanganui Chronicle<sup>42</sup> discussed new law after the defeat of the mental health amendment. This story identified a case where a man with intellectual disability, released when new mental health legislation had been legislated in 1992, went on to kidnap a young boy with an intention to sexually assault him. It also quoted Warren Brookbanks, the author of the discussion paper on legislation for people with intellectual disability, who referred to "political and media over-reaction".

### **5.5.1 Stand-alone legislation**

In January 1995 the Minister of Health identified in a letter to the MOH the need to prepare legislation. It would be named the "Compulsory Care and Protection Bill". It identified that an amendment to the Mental Health Act presently before the Social Services Select Committee

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<sup>41</sup> The Evening Post 9.12.95

<sup>42</sup> Wanganui Chronicle 20.12.95

was unlikely to go ahead. In the opening paragraph the Minister stated that “The Bill is intended to protect the rights of people who in their own interests require restrictive treatment and who are unable to give consent”<sup>43</sup>. The minister stated that the Bill should be introduced no later than 31 October 1995 and passed by 1 July 1996.

By 30 January 1995 a report had been sent to the Minister of Health and the Associate Minister of Health which discussed issues relating to the management of “certain offenders with intellectual disabilities”<sup>44</sup>. This report identified that most attendees at a working party meeting had thought it inappropriate to have stand-alone legislation for people with intellectual disability on the grounds that intellectually disabled people did not commit crimes at any greater rate than the average population. Nor was it considered appropriate to have them included in mental health legislation. There was, however, some concern for a few who might need to be subject to restrictive treatment (seclusion and restraint). For these people a legal mechanism would be needed.

### **5.5.2 Judicial involvement**

On 31 March 1995 the Legal Research Foundation in association with the Mental Health & Disability Law Subcommittee hosted a conference at Auckland University. The conference heard from lawyers, a judge, a doctor, two psychiatrists, the Deputy Director of Mental Health at the MOH, a senior law lecturer and the President of the Australian New Zealand Association of Psychiatry, Psychology and the Law. Issues were raised relating to the difficulty for courts of disposition for intellectually disabled offenders.

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<sup>43</sup> Request for a Bill to be included in the 1995 legislative programme. Dated 16.1.95.

<sup>44</sup> Report of a meeting to discuss issues relating to the management of certain offenders with intellectual disabilities

By the 26 April 1995 discussions had been held at the MOH and a decision was made to approach Warren Brookbanks to draft a discussion paper on compulsory care for intellectually disabled people.

A Cabinet Paper, dated 10 May 1995 identified that a pilot study to find out how many intellectually disabled people were in prison in New Zealand had been initiated<sup>45</sup>.

### **5.5.3 Protection of Personal & Property Rights Act 1988**

In attempting to find a way to control people with intellectual disabilities whose activities gave the courts cause for the concern of public safety some discussion centred on using the Protection of Personal & Property Rights Act 1988 (PPR Act).

On 12 July 1995 a District Inspector of Mental Health postulated using the act in conjunction with other legislation to effect a disposition that would be satisfactory to courts.

Discussion took place during the latter part of 1995 between MOH and Ministry of Justice staff on the possibility of using the PPPR Act to control people with intellectual disability who offended criminally, or were deemed to be dangerous. In that discussion it was recognised that the Act was designed to promote and protect the rights of people who were not able to manage their own affairs and was not to be used to control their activities. It then stated “the intent of the PPPR Act could become confused...(and) ...has the potential to further stigmatise individuals with disabilities, by drawing a relationship between their disability and offending behaviour”.<sup>46</sup>

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<sup>45</sup> Brandford, 1997.



An internal MOH memo dated 10 August 1995 discussed a meeting with the Minister of Health on deinstitutionalisation<sup>47</sup>. In this memo the Minister expressed concerns about releasing a small proportion of institutionalised people into the community who were believed to constitute a danger. There was some discussion, initiated by the minister, on keeping a small number of people 'on site' in smaller secure institutions. However, ministry officials identified that keeping people in institutions was more costly than keeping them in the community. The themes of 'costs' and 'keeping them in check' pervade the document.

#### **5.5.4 Deinstitutionalisation and 'rights'**

By 8 September 1995 issues relating to the release of people held in institutions had been discussed in a Memorandum for the Minister of Health titled "Deinstitutionalisation Planning-Provisions for those needing safe and secure care." Primarily this document dealt with people with intellectual disability that might require secure supported accommodation. The document also discussed the issues of using the PPPR Act to detain people, however this option was not developed further. The document identified that Warren Brookbanks had been commissioned to draft a paper on compulsory care legislation. Concern for what would happen when the major institutions such as Templeton, Tokanui, Kimberley and Ngawhatu released their patients was also raised.

A brief discussion ensued on whether secure facilities such as mental health units should be provided for those who were considered to present a serious risk to the community. However cost was again raised and it was argued that such facilities were more expensive to run. An

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<sup>46</sup> MoH letter to Dept of Justice, dated 15.8.95.

assessment of the numbers of people who needed secure care was provided for two of the institutions named above. The paper argued that without legislation “the appropriateness of keeping people with intellectual disability in custodial situations will be challenged”. This comment indicates the perceived need to legally justify the actions envisaged, a sequence of perception, action then legislation, perhaps.

Another MOH Internal Memo dated 10 November 1995 indicated that the ministry was looking at using specific legislation for people with intellectual disability who were considered to be “dangerous” and using the PPPR Act for those who were considered a risk to themselves. There is a sense that the Ministry was trying every conceivable avenue in the search to find a way of resolving the problem as quickly as possible. The memo also recorded that Warren Brookbanks’ discussion paper<sup>48</sup> had been forwarded to the Minister of Health and a briefing paper outlining the scope and direction of the compulsory care project was attached. In the briefing paper concerns were raised about the sensitive nature of custodial care because of community concerns for human rights.

However the issue of inadequate services for those groups that the legislation would cover was also identified. The concern appeared to refer only to a shortage of ‘secure’ support services. Perhaps this definition of a lack of services indicated the type of thinking that was prevalent in the Ministry of Health. Yet previous papers had quite clearly identified that restrictive environments and a lack of stimulating experiences were considered to be the main cause of challenging behaviours, often equated with ‘dangerousness’.

Ministry of Health correspondence at the end of 1995 indicated that they were in discussion with the Ministry of Justice with whom they

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<sup>47</sup> The process of moving disabled people from institutional to community care

would work on proposed compulsory care legislation. The Mental Health Amendment Bill, which would have put intellectual disability back into mental health legislation as grounds for being found 'mentally disordered', was unlikely to become law.

Mid December saw an urgent memorandum sent to the Minister of Health from MOH regarding the management of persons with intellectual disability. At this time the government was trying to attract support for its legislation by sending letters to the leaders of all the political parties.<sup>49</sup> Also on this day the Minister of Health issued a press release concerning a discussion paper, prepared by Warren Brookbanks, about people with intellectual disability "who present a serious risk to others".

In late 1995 a MOH document, undated, gave an "Historical overview of deinstitutionalisation of people with intellectual disabilities". The overview provided a commentary on the process and progress from 1973 to the present time. It described the United Nations conventions on 'rights' for people with disabilities, and identified the numbers of intellectually disabled people in institutional care. It recorded that "in August 1990, the Labour Government formally adopted the policy of deinstitutionalisation". The philosophy of "normalisation" clearly was given importance with the definition being included, that is "making available to the mentally retarded, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society"<sup>50</sup>.

The overview gave details of the international "Proclamation on the Full Participation and Equality of People with Disabilities in the Asian and

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<sup>48</sup> Brookbanks, 1995

<sup>49</sup> Dated 13.12.95

<sup>50</sup> Historical overview undated

Pacific Region". It ended with the statement by the then Minister of Health who said, "the signing of the international proclamation today sends a clear message that the Government is committed to furthering the rights of people with disabilities in New Zealand by including them wherever possible into the mainstream of society".

By the end of 1995 newspapers had reported on the hundreds of dangerous people who would soon be released from institutions around the country. The MOH had opted for 'stand-alone' legislation and invited a law academic to prepare a discussion document, and the legal fraternity had held a conference on compulsory care legislation.

## **5.6 1996**

A story in a local West Auckland community paper<sup>51</sup> included the headline "Dangerous man free". The article dated 21 May 1996 reported that a 21-year-old man was described as 'Dangerous' yet the charge relates to the theft of a bar of chocolate. His history was then raised in court to identify that he was once dangerous and could be so again indicating a probability of regression. It was noted that he had impulsive violent outbursts, had accosted young girls and stole women's underwear. The judge told the man "If I let you leave here today no one knows where you will stay tonight... you have already spent ten days in prison while we tried to work out how to deal with you". The judge continued, "A custodial sentence is too harsh for such a minor offence and you don't qualify to enter a mental hospital for treatment (obviously a reference to dangerousness and not the chocolate bar). We have tried to find you a place where you can stay and be cared for. But we can find no such place".<sup>52</sup>

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<sup>51</sup> Western Leader 21.5.96

<sup>52</sup> Western Leader, 21.5.96 Headline "Dangerous man free".

In August a provincial Taranaki newspaper reported a Member of Parliament saying that residents of the Kimberley Centre were being held against their will through the misuse of legislation<sup>53</sup>, in this case the PPPR Act. The article raised the issue of danger from the residents to the community.

In early September The Sunday Star-Times reported, under the heading “Court to rule on care for psychiatric patient”<sup>54</sup>, the story of a man with intellectual disability who ‘absconded’ from his service accommodation. “Caregivers found him as he was about to board a bus”. The story highlighted his history of criminal offending and that he had been held in a secure psychiatric unit. The lack of funding for high quality services and the lack of appropriate services was also emphasised.

### **5.6.1 Expert advice**

In March 1996 an internal memo of the MOH briefly discussed an in-depth report completed by Garth Bennie on the needs of people with intellectual disability with accompanying ‘challenging behaviour’.<sup>55</sup> The main issues identified were:

- Poor access to mental health services
- Inappropriate prescribing of psychotropic drugs
- Inappropriate use of aversive procedures
- The need for individualised service approaches
- The link between challenging behaviour and the persons environment
- The lack of access to services such as day programmes because of the behaviour
- The lack of non-staff friendships and acquaintances even in community-based settings
- Institutionalisation
- Over-representation of Maori with challenging behaviours

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<sup>53</sup> Dated 3.8.96. Headline “MP says patients are imprisoned”.

<sup>54</sup> Dated 1.9.96, Page 3.

<sup>55</sup> Dated 4.3.96.

The report did not indicate a need for seclusion, restraint, and the further use of medication (psychotropic drugs). It provided a clear indication that the methods for handling people with challenging behaviours, described earlier in this chapter, were likely to be the cause of the behaviour and not expedite behaviour improvement.

The early part of 1996 saw the Ministry of Health, the Ministry of Justice and the Crown Law Office all working on the legislative process. One of the streams in the process was defined as “the development of new legislation to protect people with intellectual disabilities”. From what is not specified.

In early April a ‘semi-urgent’ memorandum to the Minister of Health discussed the legislative framework for compulsory care legislation. It noted that submissions on the Brookbanks paper had been received.

### **5.6.2 The Brookbanks Discussion Paper**

Brookbanks’ all encompassing paper canvassed many ideas and principles in its discussion on compulsory care legislation for people who have an intellectual disability.

The document asserted “offending by intellectually disabled persons is directly related to levels of community care and support and the availability of specialist services” (p. 2). The report added that “such services have tended to be less and less well resourced and are regarded as grossly inadequate” (p. 39).

The paper suggested that people with intellectual disability would require innovative legislation and distinctive care supports in the manner of welfare guardianship rather than a more medicalised model of service. He also argued that without suitably effective advocacy “once

in the system their disability, their often difficult social circumstances ...make them especially vulnerable to official intervention and consequent institutionalisation' (p. 3).

In contradiction to the belief that the principle of Normalisation required that people with intellectual disability be dealt with as any 'normal' person, he declared that "the principle should not be applied in such a way as to ignore the real social, economic and health disadvantages already experienced by this group" (p. 77).

Discussing the vexing issue of 'dangerousness' Brookbanks opined that protecting the community might be better served by providing care and treatment that "encourages the offender to become an acceptable member of the community rather than through custodial measures' (p. 6).

Ethical concerns received an in-depth appraisal especially in regard to the concept of 'preventive detention', which is the ability of the court to provide for an indeterminate sentence length. There was disquiet in the report that preventive detention might be disguised as 'care' to prevent the person being returned to the community and perhaps re-offending.

Also discussed was the need to take into account the special needs of people with an intellectual disability in line with international covenants on the rights of the disabled and New Zealand human rights legislation.

Brookbanks' discussion paper was distributed to government agencies, human service providers and other interested parties.

The debate concerning 'rights' was raised in early 1996. In a report dated 30 April a Ministry of Health official indicated the necessity of

providing the Minister of Health and the Ministry with a census of people who would be subject to the legislation because of “the inevitable debate about the consequences of depriving people of their liberty”.<sup>56</sup>

It is apparent that there were some difficulties regarding ‘rights’ to be negotiated for, as in a ‘project specification-mental health services section-1996/7’ document the legislation was described as having “high political profile”. Also at this juncture in the MOH files is a copy of a Michael Kendrick presentation on “Some examples of elements of the community living thrust which have been problematic or worrisome to many people”. In the copy were 20 points. Many of these related to problems already identified in Ministry papers, such as uninspiring daytime programmes, equating community care with community integration and human service organisations being stranded in institutionalised thinking patterns.

In late January 1996 responses were received from a number of interested organisations to the Brookbanks paper. The organisations ranged from government agencies e.g. Police, Health Agencies e.g. Midland Health, The Privacy Commission and Human Service Agencies, for example IHC. The summary of responses indicated general support for the legislation with some issues causing concern. The issues ranged from costs and resources to explanations of terms such as ‘serious danger’. However none of the organisations expressed concern as to why it was considered necessary to pass the legislation or what the unintended legislative outcomes might be. This was reflected in a MOH memorandum asking the Minister of Health to view the attached summary of responses to the MOH discussion paper on compulsory care legislation. The memo concluded that there was no need to make changes to the proposed legislation.

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<sup>56</sup> Internal MOH memo.



On the basis of the submissions the Ministry of Health produced a position paper<sup>57</sup>. The paper clearly identified the two groups who appear in the final legislative draft, the offender group and the non-offender group although not specified as such. However the number of people thought to be likely subjects of the legislation was put at 100. However, other than numbers, the position paper reflected closely the final draft Bill.

A 20 August 1996 Cabinet Social Policy Committee paper had discussed the difficulties criminal courts were experiencing in dealing with people who had intellectual disability and committed offences.

In November 1996 a routine memorandum to the Minister of Health indicated that a previous estimate of 100 persons who might have come within the orbit of the legislation should be revised to 140. In February 1997 the figure rose to 220.<sup>58</sup>

### **5.6.3 Establishing an Advisory Group**

In October 1996 in a letter to the Regional Health Authorities the Ministry of Health indicated that an advisory group would provide expert assistance to the Ministry. The advisory group would comprise representatives from the Regional Health Authorities, The Ministry of Health and management and clinicians of human service agencies.

Ministry of Health files identified that the first Advisory Group meeting was held on 30 October 1996 at the Ministry of Health building in Wellington. Present were clinicians, service providers representing the

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<sup>57</sup> Proposed legislation to facilitate the compulsory assessment, care and support of persons with intellectual disability: A position paper, dated May 1996.

<sup>58</sup> Memo to the new Minister of Health dated 19.2.97.

major services, a representative of the Regional Health Authorities, a representative of Maori, a researcher, a legal advisor, an economic advisor and a number of MOH officials. The meeting ranged over a wide variety of topics, including how the proposed legislation would interface with existing legislation and who the people were that would be subject to the legislation. The number estimated, 200, suggests that the civil population were already being considered as possible subjects for the legislation, for early estimates of those who would enter the legislation via the criminal courts was given as approximately 50. To facilitate communication with the Advisory Group teleconferencing was also employed.

Very late in 1996 a senior MOH analyst wrote to members of the advisory group requesting feedback on a Ministry position paper. It is apparent from the documentation that the Advisory Group was involved at each step of the process and was kept abreast of current Ministry thinking.

The year 1996 saw the impetus towards providing stand-alone legislation quickening. Reports from various academics provided the government with information on the needs of people with intellectual disability and the complexities of preparing legislation for them.

## **5.7 1997**

A 1997 report by Olive Webb, employed by the IHC, entitled 'Patterns and Consequences of Offending amongst People who have Intellectual Disability' discussed a study of a large number of the organisation's clients and the issue of criminal offending. It identified that 12 alleged offenders with intellectual disability were tried and found guilty. It also identified that nearly 80% of their clients who had contact with the

police as alleged offenders were not prosecuted. The report concluded that offending among people with intellectual disability in its service approximated that of the general population with no one particular area of criminality being particular to people with intellectual disability. It also pointed out that prejudice, described in the report as a hangover from previous centuries, had a negative effect on the way the general population viewed the intellectually disabled.

In an earlier 1996 paper "Intellectual Disability and the Law" the author Olive Webb had argued that the change in mental health law and political debate had focussed attention on intellectually disabled offenders. Webb confirmed that some people with intellectual disability who had been held in mental health or psychopaedic hospitals who were released after the 1992 Mental Health Act was passed had offended against the public. Webb also stated that:

The response to these events within the media and by some politicians raised spectres of some of the worst, negative stereotyped views of people with intellectual disabilities... (and)... the assumed 'risk' of people with intellectual disability in community settings remained a political football, kept in play by several tragic events involving people with mental illness (not intellectual disability).<sup>59</sup>

In January 1997 an internal memo of the MOH identified that the Legal Services Section was asking how it could become more involved in the development of the legislation. The memo also specified that the legislation was and would continue to be a priority even with a new Minister of Health.

In a February memo figures were given for the cost of providing the services that the legislation might require. In the cost analysis the number of people used to show possible rises in funding requirements were in three brackets, 200, 300, and 400. Whether this meant that

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<sup>59</sup> Intellectual Disability and the Law, Olive J. Webb Consultant Healthcare IHC New Zealand Inc. 1996.

those numbers were probabilities was not specified, but may give an inkling of the number of people who were seen as having the potential to need compulsory care in the future.

In the Manukau Courier newspaper in March 1997 a headline demanded, "Does someone have to die first?"<sup>60</sup> The story related how a staff person had been viciously attacked and spent four years recovering. The story also related that the offender was free to wander wherever he wanted. In this particular story the police were critical of the staff members for breaking service rules, which may have caused the problem. Staff members complained that the person should have been held in a secure unit. On the same page another story relating to the same set of circumstances argued that the person with the intellectual disability did not fit the requirements to be in a secure unit. The story reiterated the man's aggressive tendencies.

In May 1997 a report to the Minister of Health discussed 'emerging issues' in compulsory care legislation. A central issue was the "very small number of individuals" who were likely to be subject to the legislation. The report mentioned that a 'stocktake' had identified about 250 people but then estimated that between 50 and 100 persons was a more likely figure. This figure included those who went to services via the criminal court system. The report then went on to state "this raises the issue of the feasibility of developing legislation specifically to deal with a very small group of individuals".<sup>61</sup> The report also identified that John Dawson, a senior lecturer in Law, had been contracted to provide advice on problems associated with legislation for a small number of people. The Minister of Health forwarded a copy of this report to the Minister of Justice<sup>62</sup>. In a 'File Note' dated 22 July 1997 it indicated

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<sup>60</sup> Dated 29.3.97, p. 6.

<sup>61</sup> Memo to the Minister of Health dated 16.5.97

<sup>62</sup> Dated 27.5.97 to Minister of Justice.

that there were fewer people than had been generally thought who were seen to need compulsory care.

### 5.7.1 The Dawson Report

In June 1997 John Dawson responded to the Ministry of Health enclosing two copies of his report titled "The Shape of Intellectual Disability Legislation". The report was extensive, covering very difficult ethical issues. As has been noted in this chapter the figures given for those persons likely to be subject to compulsory care has altered often and numbered from 50 to 400 at different times. Dawson stated, "in my view, **a compulsory care regime should only be enacted if it is accepted from the outset that its use will be considerably greater than is currently contemplated.** Once introduced, it will be very difficult to remove" (p. 15). Dawson discussed this conclusion in greater depth. He indicated that in law reform the numbers often turn out to be greater than anticipated for a number of reasons. These included:

- Compulsory care will become a social institution, which may generate its own demand. Its existence may diminish the use of less restrictive means of delivering care, or prevent their development"(p. 14).
- Services will "leapfrog" the queue, using compulsory care to gain funding.
- Services may use compulsory care to gain the protection of the 'flak jacket' potential of the law. This section deals with the unlawfulness of detention, restraint and treatment without consent in light of 'rights' legislation.
- People with intellectual disability cannot be cured, therefore the person subject to compulsory care may be detained for a lengthy period of time. Inevitably numbers will increase.

In this report Dawson also examined the options of different legal responses to the perceived problem of disposition of intellectually disabled people who have accompanying challenging behaviours. His conclusion was that 'stand-alone' legislation was the better option, though not necessarily in the form designed by the Ministry of Health.

In a cabinet paper dated 21 August 1997 authority was requested from Cabinet to proceed with developing legislation for dealing with intellectually disabled people who committed criminal offences.

At about this time the MOH were contacting members of the Advisory Group who were specialists in the field of intellectual disability to discuss the boundaries compulsory care legislation should have<sup>63</sup>.

In September 1997 a memorandum from the IHC discussed in some detail the proposed compulsory care legislation. Serious concerns were raised about how people with intellectual disability who had 'challenging behaviour' were being managed. The memo identified the problem of a perception that there was a large group of people with intellectual disability who were considered dangerous, which they argued was, in fact, not true, supporting the comments in the previous 'file note'. The memorandum then went on to outline ten key points for successful service delivery. Some examples included:

- Individualised service planning and delivery to meet specific needs
- Reducing challenging behaviour (the reason for the legislation) requires other factors, e.g. communication, be addressed and not simply the perceived problem behaviour
- Residential care should be in small homes or apartments not in large residential centres<sup>64</sup>.

It also referred to another report prepared by the author for the MOH regarding people with intellectual disability who also had 'challenging behaviour'.<sup>65</sup>

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<sup>63</sup> Letters to MOH dated 2.9.97; from Waikato Community Living Trust. C.L.T. dated 3.9.97; IHC facsimile dated 3.9.97.

<sup>64</sup> Dated 3.9.97, subject Compulsory Care Legislation

<sup>65</sup> The Support of People who have Challenging Behaviour- a review of Past and current Practice and Outcomes (1997).

On 11 September 1997 a phone call between John Dawson and a senior staff member at MOH involved discussion of the common law right to hold and treat people. It also discussed legislative options. Dawson stated that “tens of thousands of elderly are restrained and held behind closed doors at any one time”<sup>66</sup>.

In a letter to the Office of the Public Advocate in Carlton, Victoria, Australia an MOH senior analyst discussed the then present position *vis a vis* the state of compulsory care legislation.<sup>67</sup> The letter discussed a possible change of direction for the legislation. “It now seems as though any legislation is likely to be targeted only at those individuals with intellectual disability who are charged with an offence, but who are unfit to plead, or who if convicted, are not appropriately managed within the Corrections services (including prison)”. This was in line with recommendations of John Dawson. The letter also highlighted the problems of inadequate service provision. “It has become evident that the proposed legislation would only relate to a small number of individuals, whose needs are primarily related to effective service delivery”.

On 11 September 1997 a facsimile marked ‘urgent’ went to MOH from Police National Headquarters in relation to a Cabinet Paper on compulsory care legislation, and discussed concerns that the police had with the proposed Bill. Of particular interest in the paper was the view that the threshold for entry into compulsory care was too high. That is, it should not be necessary to pose a ‘serious’ risk of harm to self or others, that a series of minor criminal acts “particularly if there is a contracting time span between them, must be an equally strong initiator of the process as a single serious offence”<sup>68</sup>.

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<sup>66</sup> Titled “John Dawson’s comments. Phone call 11.9.97.

<sup>67</sup> Dated 4.9.97

<sup>68</sup> Dated 11.9.97.

Other people on contract to the MOH were working on the legal frameworks for compulsory care legislation and ‘treatment without consent’ at the end of 1997. The treatment without consent issue created serious ethical problems as psychotropic drugs were often used to manage (quieten) people with intellectual disability rather than to make them well. This discussion paper argued the pros and cons of compulsory care when held up to the scrutiny of international covenants on human rights. The question was posed, were the restrictions appropriate and just or inappropriate and unjust and if they were could the injustice be justified as a reasonable limit to freedom in a free society?

A draft paper for the Cabinet Committee of Health and Social Policy furnished a clue as to why the ‘civil population’, the non-offenders, were finally included in the legislation proposal. On page seven of the document under the heading “Risks of Extending Compulsory Care Legislation to People Not Charged with an Offence” it stated that it “may provide greater surety of safety against harm than an approach based on service development and guidelines”.<sup>69</sup> The ‘harm’ referred to was subsequently identified as harm to the community. The discussion also noted that “public fears and condemnation is not sufficient justification for the abrogation of a right” (p. 8), in this case, the right to be free from unlawful detention.

In another paper, undated, but issued at about the same time as the above paper the ‘civil population’ was again discussed. That paper mentioned that service providers were concerned that they had insufficient legal powers to manage people with challenging behaviours as identified in the Dawson report. It continued “providers want to

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<sup>69</sup> Draft for Officials Committee 16.9.97



know clearly the scope of their authority to detain, secure, restrain and treat without consent, to prevent their actions being found unlawful as an infringement of 'rights' of the individual even though they have acted reasonably and professionally"<sup>70</sup>. The paper noted concerns that the public was at risk from such people due to their right to decline support and services. The paper further identified that the public's fears were caused by continuing deinstitutionalisation as people with challenging behaviours were more visible to the community and "a few highly publicised cases of people discharged from psychiatric hospitals since the 1992 law change".

The paper made plain that no decision had yet been made on who would come within the scope of the proposed legislation. In an appendix to this paper the figure for the 'civil population' was given as 220. A breakdown on the types of challenging behaviour people with intellectual disability presented was provided, ranging from violence towards other people to threats of murder. The two major areas identified were violence towards other people and sexually inappropriate behaviour, which accounted for 95% of the 220 people in the civil population. A further item of interest was that 58% of the people identified were still in institutional care.

On 13 November 1997 a draft copy of a study of 'Intellectual Disability among New Zealand Prison Inmates' was faxed to the MOH from the Office of the Ministry of Corrections. The study found that 13 people with intellectual disability were identified in the prison system. The rate of offending was calculated to be no higher than for the general population.

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<sup>70</sup> Office of the Minister of Health, Cabinet Committee on Health and Social Policy, Intellectual Disability (Compulsory Care) Bill- Options for target population.

Further communication with John Dawson occurred. He was employed as a regular sounding board for MOH officials with regard to legal options.

A facsimile dated 9 October 1997 from the police commenting on a later redraft of the legislation indicated that there was a high degree of activity at the MOH on the Bill. A Ministry of Justice letter, dated 10 October 1997, to MOH officials provided a discussion paper for a meeting of government agencies that was to occur on that day, suggesting increasing interdepartmental activity.

Another Ministry of Justice letter to its own Minister dated 28 October 1997, indicated that there would be a meeting with the Prime Minister and the Minister of Health on the 30 October with the subject being compulsory care legislation for intellectually disabled people. The letter reiterated the change in the thrust of legislation from including people who did not commit offences but were a danger to themselves or others to excluding that group. However it stated that that particular question would be discussed at the meeting. It again mentioned that the difficulties of that particular group could be solved through better service delivery. Of particular note in the letter was the awareness that compulsory care legislation would by-pass the right to be free from discrimination on the grounds of disability, a 1993 addition to the Human Rights Act.

In November 1997 there was a flurry of activity that included an internal memo relating to a Cabinet Committee on Health and Social Policy meeting scheduled for 12 November. The writer asked for a waiver on the 'ten page rule'. It appears that papers to the meetings should be shorter than ten pages. The waiver was sought because of the

“complex nature of the issues”.<sup>71</sup> Further correspondence on that date identified that the legislation would have implications for the Ministry of Justice, Police, Department of Corrections, Department of Courts, Social Welfare, Ministry of Women’s Affairs, Te Puni Kokiri and Treasury, reinforcing the notion of increased inter-departmental activity.

One outcome of the meeting of the Cabinet Committee of Health and Social Policy was another request to John Dawson to critique additional documents.

A copy of a draft press release, dated 8 December, on the findings of a survey into the number of intellectually disabled persons in prison<sup>72</sup> asserted that the possibility of releasing such people into appropriate services would be able to occur under compulsory care legislation.

In notes made of a teleconference with the “Advisory Group on Intellectual Disability (Compulsory Care) Legislation” it was noted that a decision had been made to include the ‘civil population’ in the legislation. This had produced a great deal of debate. The consensus was that the ‘civil population’ should not be included in the legislation. Inclusion would not be in “compliance with international rights”<sup>73</sup>. The documents also discussed difficulties that the advisory group had with the criteria for ‘dangerousness’.

In a Draft Background Paper there was information about what ‘compulsory care’ entailed. The paper identified two groups. One is the “ordinary compulsory care regime” the other is “special status”<sup>74</sup>. The paper set forth a range of options for care. Special status clients would

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<sup>71</sup> Letter from the Minister of Health to the Secretary of the Cabinet, dated 6.11.97.

<sup>72</sup> Brandford, 1997

<sup>73</sup> Dated 10.12.97.

be given 'secure care', which meant physical barriers plus a range of supervision. 'Supervised care', another option for those who have compulsory care rather than special status entailed "typically ... 24 hour support".

At the end of December 1997 MOH documentation detailed a new timeline for implementation of the legislation which had been deferred until early 1999.

1997 had provided another influx of reports to the Ministry of Health and a consequent flurry of work in that department. The decision to positively include the civil population of intellectually disabled people into the act had after some seesawing at a high government level been decided.

## **5.8 1998**

### **5.8.1 The failed experiment**

1998 began with numerous newspaper reports that argued against the continued deinstitutionalisation of the mentally ill and the intellectually disabled. Some articles went so far as to pose the idea of reinstitutionalising those who had been brought into the community. For example in January 1998 an article written by politician Mike Moore argued that the policy of deinstitutionalisation had been reversed in Britain and should also be reversed in New Zealand. The column insisted that "the experiment has failed"<sup>75</sup>. A Health Link South manager added, "the Government was fully aware of public pressure to reverse its policy". A similar story was also run a few days previously in

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<sup>74</sup> Dated 11.12.97. From the Office of the Minister of Health.

<sup>75</sup> The New Zealand Herald, 19.1.98 page a3.

the Sunday Star-Times under the heading “Mentally ill to return to hospital”<sup>76</sup>.

In January The New Zealand Herald reported the death of a woman who was scalded to death in a bath<sup>77</sup>. The story said that the woman had spent the previous thirty years living in an institution. A further article in the New Zealand Herald on 20 January 1998 headlined the problem of “Mentally ill given freedom not care”. These reports had the effect of reinforcing Mike Moore’s argument that some people are better cared for in institutional settings. For instance, in a letter to the Editor of the Evening Post under the heading of “Support for families”, the family of an intellectually disabled person decried the fact that their intellectually disabled relatives had been brought into the community only to be neglected, mismanaged and finally shuffled into the justice system<sup>78</sup>.

### **5.8.2 Ministry activities**

The early part of 1998 saw a continuation of the high level of activity within the MOH and other Ministries. In January 1998 John Dawson provided a ‘Progress Report’ on his critique to the MOH. Among the papers to critique were two ‘rights’ papers. Of these he said, “my principal comment is that the most important ‘rights’ issues have not been tackled yet and discussed in these papers”.<sup>79</sup>

One such difficulty regarding ‘rights’, in this case the right to freedom of movement, was identified in a ‘Health Legal’ paper, dated 21 January 1998. Discussing the ‘civil population’ it stated that “it is important to make it clear in this addition criterion for the civil population, whether or not the “serious danger” must be actual, or merely potential (i.e.

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<sup>76</sup> Dated 18.1.98

<sup>77</sup> Dated 15.1.98.

<sup>78</sup> The Evening Post 12.2.98

would the person need to have already demonstrated a dangerous tendency, or would it be enough that the person's condition predisposes or makes them more likely to be dangerous?)”.

A facsimile from the Department of Corrections on 23 January 1998 also disclosed some difficulties with the proposed legislation. However because of the complexity of the discussion the writer asked to discuss it over the phone or in person. No mention of the nature of the problems was made on paper. In this same paper, the writer referred to dealing with 'requests for assessments of prison inmates' who might be intellectually disabled and may therefore be eligible to receive compulsory care outside of a prison setting. The writer indicated that to prevent "opening the floodgates" applications should be dealt with only by prison Superintendents or a person delegated by the Superintendent. Perhaps the Department of Corrections believed there were a larger number of such people being held in prison than the 13 identified in a previous census.

Communications from the Ministry of Justice to the MOH also showed some discussion on problem areas that might arise between compulsory care legislation and other law.

Internal MOH notes of a meeting held on 28 January recorded a problem with the term 'dangerousness', identified in the 'Health Legal' Paper. The problem was that persons in the 'offender group', unlike the 'civil population' did not have to be 'dangerous', they merely had to commit an imprisonable offence to become subject to compulsory care orders. However to be released from compulsory care all had to be assessed as 'not dangerous'. The problem was that the offenders might never have been dangerous. The question was, how could they be held

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<sup>79</sup> Dated 14.1.98

past the first review date if they were not deemed dangerous? It would seem that they could not. This would pose another problem for the courts because without high quality services during and after the term of the compulsory care order the person would in all likelihood re-offend.

Late in January there were further meetings at ministerial level in order to prepare for a Cabinet meeting in February to discuss compulsory care legislation.

An internal MOH memo reflected continuing inter-departmental discussions with Department of Courts and Department of Justice. Also in this memo was a discussion of legislative considerations. These included the small number of people likely to be subject to the legislation. The 'civil population' was numbered at 200. The paper also stated that most of the people would have "long term challenging behaviours".<sup>80</sup> It mentioned that once the "initial 'hump'," was dealt with there would be fewer each year. As the initial review of the order is after 6 months it might be assumed that, taking into account the previous comments, those under the orders would not be released. The paper also identified that succeeding reviews of compulsory care orders would be at greater intervals.

Correspondence from the Police on 17 February showed that they had problems with the term 'serious danger', believing that it set to "high a threshold" to prove and that they preferred "at risk of serious harm" or "likelihood of serious harm". The difference being that a person could then be arrested on the basis of their 'potential' dangerousness rather than a realised danger.

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<sup>80</sup> Dated 1.2.98

A Treasury paper indicated that Ministers had not yet fully decided to include the 'civil population' in the legislation. There appears to be an amount of confusion or perhaps a concern about possible reactions to the inclusion of the 'civil population'.

In MOH papers covering meetings for the week 16- 22 February 1998 a number of issues relating to compulsory care legislation were identified. On 17 February a meeting of the Health and Social Policy Committee would review compulsory care legislation. A further meeting on the same subject was planned for 18 February, which would include The Prime Minister, the Minister of Justice, and other high-ranking ministers of the crown. Also included in this paper was a briefing on the deinstitutionalisation of Templeton, Kimberley and Seaview Hospitals with their perceived high needs clients who might require compulsory care.

On 24 February a paper to the Cabinet Secretary from the MOH had included a section on service requirements for people who would be under compulsory care legislation. Seven service gaps were described. They included lack of trained staff at all levels and too few people who were able to assess people with intellectual disability who had accompanying challenging behaviours. Residential options were in short supply and insufficient vocational options existed.

A letter from the Health and Disability Commissioner to the MOH on 2 February 1998 in response to an invitation to comment on draft legislation included an in-depth appraisal of rights issues that would need to be addressed in the event of the legislation being passed. The commentary centred on 'rights' and the duplication of rights in the proposed legislation. The Commissioner made the point that the rights to be contained in the legislation would overlap with the 'Code of Rights'



in the Health and Disability Commissioners Act. The rights referred to relate to quality of service provision, the facilities to be used and monitoring of the service. In what appeared to be censure of the draft act the Commissioner declared that the new legislation would override some rights in the Code of Rights. The Commissioner was at pains to correct a misunderstanding in the draft, regarding the powers in the Code of Rights. The Commissioner indicated that “nothing in this code requires a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment”<sup>81</sup>. This statement reinforces the fears mentioned in the Brookbanks paper about ineffective advocacy and the likelihood of reinstitutionalisation of this group of people.

On 3 February 1998 in draft Cabinet Papers the decision to include the ‘civil population’ was confirmed. ‘Secure Care’ was described as having “locked doors, break-resistant windows (or bars), walls and/or perimeter fences”.<sup>82</sup> In the section titled ‘Supervised Care’ behaviours including damage to property were viewed as challenging enough to require 24-hour care. Here the idea of dangerousness to self and others was apparently expanded to include property.

February 1998 saw a number of responses to the MOH draft legislation. Included were responses from its own legal experts and from the Law Commission. The response from the Law Commission identified a number of problems with the draft especially in terms of the “ambiguities in its content”.<sup>83</sup>

In February 1998 John Dawson completed his critique of MOH documents. This 45-page document covered a wide range of topics and

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<sup>81</sup> Dated 2.2.98, p.4.

<sup>82</sup> MOH Draft Cabinet Papers dated 3.2.98, p. 3.

<sup>83</sup> NZLC dated 5.2.98.

issues. One in particular was the issue of discharge from compulsory care. Dawson believed that the same criteria should apply for release as entry. This again raised the problem of dangerousness as not all those who commit crimes are dangerous.

Compulsory Care Legislation was discussed at a Cabinet Social Policy Committee meeting on 3 March 1998 which included five Cabinet Ministers and officials from the Department of the Prime Minister, Treasury, Ministry of Justice, State Services Commission and the Office of the Minister of Finance. They were talking about 200 intellectually disabled people.

On 30 March 1998 a letter to the MOH from the Ministry of Justice discussed statutory powers to detain, seclude and medicate people without consent. The letter pointed out that the New Zealand Bill of Rights Act 1990 needed to be taken cognisance of in regard to the issues under discussion. To circumvent the Bill of Rights would require statutory powers within any legislation that gave explicit consent to the described activities.

In a letter to the Police an official of the MOH described what was meant by detention, restraint, take, retake, apprehend, transport, seclude, and medicate without consent. Under medication the writer identified that the person being medicated may be given drugs for short-term periods or long term to manage behaviour. Describing restraint, the author identified body to body restraint or the use of drugs (chemical restraint).

In June 1998 the date for bringing the Bill to Parliament was again deferred three to four months. Implementation of the legislation was identified as March-May 1999.

### 5.8.3 Media coverage

The Evening Post on 25-3-98 ran a report headlined "Handicapped man remanded in Jail". It was a story of a man who had walked out of Kimberley Centre and then assaulted members of the public. He was remanded to prison when the judge considered that the risk to the public prevented him from considering other, less draconian, options.

On 4, 6 and 7 April 1998<sup>84</sup> a series of articles were published with headlines reading, "Dying to live life on the outside", "When caring is just not enough", "struggling to cope with a one-man crisis". The articles discussed service quality in the community, the arguments for and against keeping people in institutions and the difficulty of trying to provide care in the community for one particular person with intellectual disability.

On 8 June two articles appeared in The New Zealand Herald<sup>85</sup>. The major one discussed whether bringing people out of the large institutions into "community care" was only putting them into smaller institutions.

Also in June a story was reported in the Waikato Times, under the headline "Fund cuts put caregivers at risk, says stab victim"<sup>86</sup>. The story emerged of poor service provision being pressured by the release of hundreds of patients from Tokanui Hospital. A large picture of the stab victim accompanied the article.

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<sup>84</sup> The New Zealand Herald, 4.4.98, p.a15; 6.4.98, p. a11; 7.4.98, p. a17.

<sup>85</sup> The New Zealand Herald, 8.6.98

<sup>86</sup> Waikato Times, 16.6.98.

#### **5.8.4 Intellectual disability conferences**

In June a two day conference entitled “Intellectual Disability: in pursuit of professional excellence” was held in Wellington. The New Zealand Psychological Association hosted the conference. Though not entirely about compulsory care legislation a number of key speakers discussed the proposed legislation. MOH officials also presented details of the proposed legislation to the conference.

The following month another conference was held, this time in Dunedin. Many of the attendees at the previous conference also attended in Dunedin. Titled, “People with Intellectual Disabilities & Offending”, it was an international conference. The keynote speakers came from more diverse backgrounds than those at the previous conference. Another difference to the previous conference became evident when a reasonably large group in the audience raised the issue of whether compulsory care legislation was moral in the context of expanding human rights legislation in New Zealand.

#### **5.9 1999**

The year 1999 started with a call, through a newspaper article, for a service that catered for people with intellectual disability that committed crimes. The story related how a man held in Tokanui Hospital for 30 years had spent the weekend in police cells because there was no where else to put him.<sup>87</sup>

A series of articles in January ran headlines of “Brothel therapy for sick”, with a sub-heading “State-funded caregivers are arranging

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<sup>87</sup> The New Zealand Herald, 26.1.99.p. a6.

prostitutes for sexually aggressive men". In this story professionals argued that not to provide a sexual outlet for the men "in our professional opinion ...will place the person and others at risk"<sup>88</sup>.

In the same paper on the same day was the headline "Sexual healing at what price?" The sub-heading read "Some intellectually disabled men with sexual problems are being taken to sex workers by caregivers". Both of these reports concerned men who had previously resided at Tokanui Hospital. In the second article a staff person stated that "many of these men had access to sex when they were in Tokanui- either with other patients or with staff".

In May an article in The Dominion headlined "Outcry over proposals for Kimberley care centre". The report argued that:

intellectually disabled pyromaniacs and sexual deviants will be freed into the community... tragedies are going to happen... Then there's the people with bizarre, socially unacceptable behaviour- some who get pleasure defecating in their hands and then flicking it at people. Many residents had problems with violence, either to themselves or other people... A sister of a Kimberley resident said there were 'villas full of such people at Kimberley'... Kimberley was New Zealand's last sanctuary for intellectually disabled people<sup>89</sup>.

The stories continued. In August stories ran on at least three occasions about a man with intellectual disability. The basic issues remained the same as in most stories. A person with intellectual disability who behaved in a challenging manner, usually in a physical sense, breaks the law. The service providing care washes it's hands of the person and the judge has no other option but to send the person to prison. In this particular case a further complication was the man's incontinence. However the story highlighted the assumption, held by some persons involved in the case, that returning this man to an institution would

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<sup>88</sup> The New Zealand Herald 2-3.1.99.

<sup>89</sup> The Dominion, 19.5.99.

give him the “appropriate care”<sup>90</sup> that he needed. The tenor of the stories indicated that institutional care was an improvement on very poor community care. The same article reported the belief of a family member that legal detention would be good for the person with the intellectual disability.

In an article on 18 August 1999, in *The New Zealand Herald*, another story regarding the same man included at the end a paragraph on another similar case. It stated, “A suicidal Masterton man with the mental age of nine was sentenced to 18 months’ jail for slashing a man with a butcher’s knife after Judge David Ongley said he had no option” (p. 4). The lack of options referred to the judge’s options for disposition.

A 1999 letter to the MOH from the new Health Funding Authority (HFA) on Compulsory Care services outlined areas that they needed clarification on. The HFA did not know what agency would be paying for the new services. It did not know which groups of people would come under the legislation, and for the first time people with Aspergers Syndrome, a communication disorder were mentioned. When information was finally released to the news media in July 1999 children with intellectual disability had been inserted as an additional target group<sup>91</sup> though there had been no mention of including this group in the MOH files. There appears to have been continuing discussion on who would be subjects of the legislation. In a response the subject of ‘secure care’ was clarified and defined as residence in an ‘institution’.<sup>92</sup>

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<sup>90</sup> *The New Zealand Herald*, 18.8.99. *The New Zealand Herald*, 6.8.99, p. a4; *The New Zealand Herald*, 3.8.99.

<sup>91</sup> Dated 3.2.99 from General Manager, Disability Support Services to MOH.

<sup>92</sup> MOH letter to HFA dated 23.2.99.

### 5.9.1 Advisory Group mailout

Letters were sent out to members of the 'Advisory Group' in the latter part of 1999. Ten letters were mailed out, four members responded. Three of the respondents provided feedback. The letter asked members:

1. Were you in favour of Compulsory Care legislation for people with intellectual disability?
2. Have you changed your opinion over the period since you were first involved?
3. Whether you have changed your opinion or not would you please identify your present position and outline why you hold it.
4. If you have any views that you feel may be helpful in my research I would appreciate hearing from you.

Respondent One answered:

1. NO
2. YES
3. My present position is: I support the intent of the present proposal (ie, considering the material sent out by the MoH .... Proposed Bill not in the House at the time of writing) for appropriate sentencing options and treatment of intellectually disabled people who commit serious crimes. I do have concerns about some of the details in the proposed Bill, and worries about the inadequacies of resources to fund the services that will be required.

However, I totally oppose the proposed Bill's extension to people with an intellectual disability who have not committed any offence. This extension to the civil population is an unacceptable violation of their rights. In supporting this group, it is an issue of resources not legal gaps.

I am totally opposed to the inclusion of children in this proposed Bill. It constitutes a gross violation of their rights as children.

4. I have major concerns about the liberty of people with an intellectual disability and how 'danger' will be perceived and interpreted by the public. It is a well known and researched fact that we have little skill or much luck in predicting future violence or danger – e.g. people with mental illness. So why should we be anymore successful with this targeted population is beyond me!

If this Bill proceeds and the civil population (ie. those people with an intellectual disability who have not offended) becomes a target it is likely that unnecessary over-diagnosis of perceived dangerousness will occur. This would be a direct result of prejudice and ignorance in the community and from systems such as the police, lawyers and the judiciary.

Respondent two wrote:

1. I was in favour of a more appropriate way to support people with intellectual disability who had offended and were not necessarily going to be able to cope in a prison environment. The current system was difficult to manage given that there were situations where lack of resources led to offending, for instance people who are unable to find any meaningful day activity or work and get into petty crime are sometimes imprisoned due to lack of resources and the capacity to fund appropriate packages outside the prison system. While I am

aware that in some areas, Dunedin for example, the courts and Healthcare Otago have a good working relationship which enables diversion and community services there is often a battle to obtain the right resources.

2. I was not in favour of the civil population being included and definitely not children and have not changed my views... (deleted for confidentiality issues)... (I) continue to lobby for the civil population and the inclusion of children to be removed from the bill.
3. My comments above in 1 stand for this response.
4. I felt that this legislation has only become necessary as a result of the failure of systems to provide adequate services and advocacy for people with intellectual disability. Given the right environment and the capacity to engage the person with intellectual disability there would be very few people who would need this bill. The numbers have been overstated and the danger is that should the bill become law there will be an abuse of the powers. Whether or not a person enters the system will rely on a level of wisdom and skill that is currently rare in this country as the judiciary have not as a whole demonstrated their capacity to understand and be sensitive to intellectual disability. An example of abuse of what was meant to be enabling legislation is the incarceration of people in Kimberley Centre under the Protection of Personal and Property Rights Act.

Respondent three commented thus

1. Yes I was.
2. Haven't changed but a bit concerned about the lack of safeguards to keep other groups of people out of the legislation.
3. The threshold of 'dangerousness' is shifting through social and funding pressures. The legislation must not draw in people who might be helped by ordinary good services. The legislation should not catch people with physical or severe levels of intellectual disability. We need to keep the threshold levels up. We mustn't use the mechanism just to get extra funding. What is important here is that the legislation is not used with/imposed on willing service users but looks to reel in those who present significant risk AND avoid/buck against reasonable provision in ways that make it difficult to manage this risk/ increase the risk. There are not enough safeguards for the client group. Regarding advocacy, District Inspectors are too individualistic in their interpretation of their role. Compulsory Care mirrors the mental health act. It is not necessarily rigorous enough in pursuit of fair play. There is a need for oversight of advocates; training- to evaluate their work. I'm of the view that there are people that need compulsory care who are from the civil population. That would prevent the inevitable downward spiral through crime to compulsory care.

### **5.9.2 The legislation**

On 5 October 1999 the Intellectual Disability (Compulsory Care) Bill was introduced to parliament. It had its first reading and the next day was given its second reading under urgency. This means that after the



general election on November 27 this year the Bill will be sent to a select committee for deliberations.

In the Explanatory Note under the heading General Policy Statement is the following quote,

This Bill sets out the limits that can be imposed on the freedoms of people who have an intellectual disability and who are in need of compulsory care, by requiring them to accept care programmes. The Bill also provides a framework for protecting the rights of individuals subject to the Bill (p. 1).

As expected the legislation covers two groups of people described in the Ministry of Health papers as the offender group and the civil group. Additional information is provided regarding the civil group. The Bill asserts that the legislation will only be used if the person will not voluntarily take up the offered care and support services.

Three sub groups of the civil population are described. They include:

- Those with a mild intellectual disability, generally indicated by an IQ of 50-70 and a serious social disability, who will not voluntarily attend services or receive care. They are generally young males who have become known to service providers, the community, and police because of their behaviour in the community.
- Those with a moderate intellectual disability, generally indicated by an IQ of 30-50 and communication problems who may sometimes become frustrated and express this in violent behaviour.
- Those who are profoundly disabled who injure themselves. (p. 1).

Further qualifications are provided regarding the civil group. These are that compulsory care is the option of last resort and will be used only where the person is in need of compulsory care and if they exhibit behaviours which, "Poses a serious danger to the health or safety of that person or of others, and cannot be effectively managed without the compulsory powers of this Bill" (p. 1).

With regard to the offender group the Bill argues that compulsory care is a better disposition option than presently available. Presently available are prisons and mental hospitals.

In relation to 'Rights' the Explanatory Note states that they have the right to be given:

- Information relating to an assessment or care order and their rights in a form that the care recipient is most likely to understand
- Respect for the care recipient's cultural identity
- Independent health and disability advice and legal advice
- Company, to receive visitors, and to receive and to send mail (pp. 7-8).

Other safeguards include one court review after six months; clinical reviews every six months and the oversight of a district inspector of mental health. " A High Court judge may inquire into any matters relating to a person under this Bill as the Judge thinks fit" (p. 7).

In an examination of the thirteen files of documentation made available there had been no mention of including children in the legislation. Yet children with intellectual disability have been slotted into the legislation under similar provisions as the adult civil population.

### **5.10 Conclusion**

The chapter has summarised a large volume of information provided from two sources. These are the Ministry of Health, and the media. It has traced the activities of those who were a party either to the instigation of or involved in the preparation of compulsory care legislation. It began with concerns by institution Superintendents, regarding the legal options for treating intellectually disabled people who have accompanying challenging behaviour. Ministry of Health files

have outlined the path that was followed to arrive at the shape of the present legislation, the involvement of outside academics, professionals in the field of intellectual disability and family members. The media has accompanied the legislative advance by reporting the activities of this small group of people and the responses by authority figures to their actions.

Chapter six will analyse this information with the intention of searching for issues, positions taken by key players and other evidence that might identify why this Bill has been presented to parliament in this particular shape.

## **Chapter Six**

### **Analysis**

#### **6.1 Introduction**

Over the last seven years I have advocated on behalf of a growing number of people who have an intellectual disability. The original role usually commenced at the point where the person had been charged with a criminal offence and was about to appear in court. In those instances where the person charged was in residential care charges were usually laid after a number of similar occurrences had frustrated the service and it was unable or unwilling to manage the person any longer. The major example is here is that of assaults upon staff persons. In some cases however the person charged had committed criminal offence such as burglary, theft or perhaps a robbery. When an examination of the crime is made the details often show a matter of somewhat trivial proportions. Nevertheless the courts sometimes treated the people quite harshly.

When the government's reaction to a small number of cases was to propose legislation that would put people with intellectual disability into compulsory care, remove their basic human rights and reintroduce treatments of an aversive nature considered by progressive thinkers obsolete and without rehabilitative value it appeared an extreme reaction. On these grounds the theory of a moral panic seemed an obvious choice and provided the impetus for this research.

It seemed certain that the evidence of a moral panic, defined in chapter two, would be clear and unmistakable. The process of confirming the existence of a moral panic as discussed in chapter three would

primarily be through an examination of the Ministry of Health files and news media reportage.

To situate the present day events regarding people with intellectual disability within an historical perspective chapter four viewed a previous era described as a moral panic. Chapter four demonstrated the ease with which people who have an intellectual disability can be identified as a danger to society.

Chapter five presented the data contained in the Ministry of Health's files on the long sequence of events leading to the eventual legislation. Newspaper and magazine reports were also included in substantial numbers.

Details in chapter five demonstrated the complexity of the legislative process and the issues involved. First there was a response to pressures for immediate action, which resulted in the preparation of an amendment to mental health legislation. When opposition to the amendment brought about its defeat stand-alone legislation was suggested. Experts in the field of law and of intellectual disability were consulted for their views on the proposed legislation.

Discussion within the Ministry and with other relevant agencies occurred over a number of years concerning the inclusion of the civil population, i.e, those people who do not commit crimes but are deemed to be dangerous either to themselves or others. The documents suggested that the decision, taken at cabinet level after swinging back and forth for some years to include this group, occurred late in 1997.

The Ministry documents showed the dilemma that officials faced trying to resolve opposing issues relating to the 'rights' of the people who

would be subject to the legislation with considerations of public safety. This is a recurring theme played out on the pages of the Ministry files with reports by the Law Commission and other experts each exploring the ethical issue involved.

Comments made by judges regarding the need to protect the public made an impact on the government for there is a record of a meeting taking place between judges and the Ministry where the judges recommended custodial care options. The Minister of Justice made comments reported in a newspaper that supported the need for custodial care, thus lending added credence to the remarks made by the judges. For Justice Department officials the judiciary and the Minister of Justice the problem was about disposition options. What to do with people that have an intellectual disability and who commit crimes or are deemed dangerous? It was a pragmatic approach. The judiciary needed to have somewhere to send criminals and the dangerous.

Yet not all the judges argued solely for the public good. On occasion comments from the bench indicated an understanding that service failure had been the main problem. That the person before the court was there because the service had no longer wished to take responsibility for the person's care and had relinquished their obligations and handed the court the problem. In one particular case the judge in his summing up declared that the problem was one of service failure<sup>93</sup>. The point being made was that if the service had performed its functions properly public safety would not have been an issue.

Though custodial care options were an obvious solution for the judiciary and the Justice Department, the Ministry of Health was obligated to

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<sup>93</sup> Personal involvement of the researcher.

provide services for people with disabilities which were in the persons best interest. Yet the Ministry of Health had to take into account the wider public safety issues, which tended to put people with intellectual disability into a position of secondary importance. Ministry of Health documents revealed that they were aware, as were some judges, that the problems that created the need for legislation were generated by a lack of poor service provision. Yet the legislation did not address that problem, it addressed only a symptom of the problem, the people. Why that should be was not directly answered in the files. It is a point however that will be considered later when discussing the theory of moral panics.

The difficulties faced by the Ministry of Health highlighted a very real moral and political controversy. That was, the legitimacy of removing the 'rights' and 'freedoms' of one group of people, or even of one person, for the 'public good'? How to balance the one against the other?

Chapter five referred to the interest groups involved in the legislative process either through invitation of the Ministry of Health or through association with people who have an intellectual disability. It distinguished those groups whose primary focus centred on the field of intellectual disability in its entirety, for instance, service providers and clinicians from those having a more specific reason for involvement. The newsworthy value of people with intellectual disability and of criminal activity embroiled the media. Law academics were involved for many reasons, so too were family members of people with intellectual disability. Some groups were a combination. An example of this was the Kimberley Parents and Friends Association where parents joined with staff to form one group.

Comments from one interest group, the MOH Advisory Group, detailed in chapter five, provides insights into the various and inconsistent positions taken on the legislation by members of the group. Their differences may perhaps give an inkling of the likely confusion of considerations in other interest groups. Though each is an expert in the field of intellectual disability their responses diverge quite markedly. For example one respondent did not agree with the Bill initially but changed their opinion on this matter but only with regard to the offender group. This respondent opposes the inclusion of the civil population and is opposed to the inclusion of children with intellectual disability.

The two other respondents were initially in favour of legislation. Both continue to favour legislation though one is opposed to the inclusion of the civil population and children. However one is also in favour of compulsory care for the civil group on the basis that compulsory care at a non-offender stage would prevent the inevitable downward spiral through crime to compulsory care as an offender.

All three have serious concerns about the liberty of people who might be subject to the Bill and about the lack of safeguards in the legislation. Concerns are also raised about how the public will perceive the intellectually disabled in terms of 'dangerousness' with the passage of the Bill into law.

Each of the interest groups had their own reasons for involvement. Motives may have been altruistic or selfish. Without clear evidence to explain the reasons behind one or other of the motives all that is left is conjecture and personal opinion.



To complicate matters the motives may have been a mixture of altruism and selfishness. As an example \$50 million was earmarked for the provision of compulsory care services over a three-year period. The argument could be put that, were human services primarily a business, then their support for the legislation would be based on self-interest. Yet if their self-image was one of philanthropy then it might be argued by them that the increased money would enable them to provide the quality services that the people who will be subject to the legislation would need. A mixture of both motives could have included the knowledge that the legislation was not the best option for the people who would be subject to it but that it would provide a better option than their going to prison or to a mental institution.

The desire to prevent people with intellectual disabilities who committed criminal offences or who were deemed dangerous from being sent to a prison or a mental institution was laudable. There is however a need to recognise the reasons for the dangerous behaviours and why people were sent to mental institutions or to prisons.

People with intellectual disability are also susceptible to mental ill health. When the health problems present the person should be treated like any other person with a mental health problem. That is, they should be put under the care of mental health professionals. The travesty occurs when the person with the intellectual disability is found to be unfit to plead during the criminal court hearing. This means that they lack the comprehension to heed the court proceedings. If the charge is considered to be of a serious nature the person may be designated as a special patient and sent to a mental institution. Mental ill health is not a factor, public safety is.

Criminal offending and dangerous behaviours are often one and the same thing. Many of the behaviours that are considered dangerous are criminalised, depending upon service management policy. In chapter five the testimony of experts from a variety of backgrounds explicitly declared that problem behaviours were very often the result of poor quality service in service situations. An argument can be made here about whether it is morally defensible to commit people who have intellectual disabilities to prison or to mental institutions for displaying behaviours motivated by harmful service provision over which they had absolutely no control. If the conclusion is no then compulsory care, with its power to remove freedoms and rights, and to implement the use of aversive techniques for controlling behaviours, should be just as repellent.

## **6.2 The analysis**

The data presented in chapter five will be analysed to consider whether or not sufficient evidence is available to support the supposition that compulsory care legislation is the result of a moral panic.

## **6.3 The theory**

In Chapter 2 a model of a 'moral panic' and its many elements was set out. It was intended that the research that followed would be guided by this model, and would verify that the compulsory care legislation was driven by such a panic. Chapter two delineated the theory at some length because it was anticipated that the research would disclose conclusively a classic instance of a moral panic. The outcome however was not as simple and straightforward as expected. The contours of all the components of the classic moral panic could certainly be glimpsed, but in itself it could not account causally for what happened.

It was necessary to review the data in Chapter 5 to discover if the essential characteristics of a moral panic were in evidence. The analysis would best be accomplished by using the key elements of a 'moral panic' as themes. In chapter two, five key distinctive features of a moral panic were discussed (Thompson, 1998). They included:

- identifying the deviant group,
- media depiction of the threat in an easily discernible shape,
- a swift intensification of public anxiety,
- a reaction from the authorities, and finally,
- the abatement of the panic or resultant social change.

As discussed in chapter two moral panics occur most often during times of extreme social stress, where public anxiety is high and moral boundaries are blurred (Thompson, 1998, p. 40). Moral panics must be seen in the light of societal structures and dynamics during this time for they do not occur in a vacuum but are part of the wider societal milieu.

There has been, beginning in the mid 1980's enormous social change in New Zealand. The basis of the changes was the major shift from a reasonably benign economy to one more conspicuously capitalistic than many other nations identified as capitalist. It was inaugurated and underpinned philosophically by 'new right' economic ideology and its proponents. Jesson (1998) asserts that where other western economies had become more pragmatic since the early 1980's New Zealand remained a Mecca for pilgrims of the 'New Right'. The transformation of the economy was accompanied by major changes in lifestyle, a greatly increased number of jobless both temporary and permanent with an attendant increased numbers of welfare beneficiaries. Jesson also argues that "inequality is higher and so is crime" (p. 21) while "there has been a quite drastic deterioration of the ethical standards of New Zealand" (p. 56). He also asserts that the public are collectively

powerless, held in thrall by international finance. Thus one plank necessary to support the assumption of the existence of a moral panic, that of social upheaval, was apparent.

#### **6.4 Identifying the deviant group**

One essential element of a moral panic is the folk devil (Cohen, 1980). They personify evil (Goode & Ben-Yehuda, 1994). They are the stereotype of the group to which they belong. Their actions are considered unrepresentative of what is normal.

During the eugenics era people with intellectual disability were stereotyped as a threat to western society. They were considered to be predisposed to criminal behaviour and immorality. The notion that they were immoral was related to the societal perception of their promiscuity and sexual offending. Women with intellectual disability were considered especially problematic because of their prolific breeding of ever-increasing numbers of similarly mentally defective people.

Through decades of segregation, sterilisation and institutionalisation those stereotypes have if anything tended to be reinforced rather than weakened. The need to stereotype people with intellectual disability is no longer necessary for they are already viewed in stereotypical fashion. The latest redefinition of dangerousness has almost certainly been based upon the already identified stereotypes of menace and sub-humanity (Wolfensberger, 1991).

#### **6.5 Media depiction of the threat in an easily discernible shape**

Unlike other 'folk devils', e.g. the 'Mods and Rockers' (Cohen, 1980) of an earlier age, the stereotyped view of this group of people is unlikely to

change unless supports are provided that will address the problems that have caused the behaviours described as 'dangerous'. Their intellectual incapacity has often prevented them from taking action on their own behalf except in ways that has strengthened the dangerousness stereotype ensuring that this group of 'folk devils' is perfectly typecast to play the role in perpetuity.

During the seven years in which the compulsory care legislation was in preparation media attention on people with intellectual disability who were deemed dangerous or criminal was periodically quite intense.

A proportion of the coverage was quite blatantly prejudiced against the people who would be subject to the legislation. The North and South article that stated "we used to call them sociopaths: now we say they have 'personality disorders'. Some are intellectually handicapped as well, their low intelligence putting them even further beyond help or conscience...eight were intellectually handicapped and dangerous" (McLeod, 1994, p. 80) is an example of this type of reporting.

Other press coverage was sympathetic to the plight of the same people and detailed the problems of homelessness and lack of services as a major cause as, for instance, in the case of the young man who stole the \$3 chocolate bar and had nowhere to live. It would not be a legitimate argument that the media represented only one particular viewpoint.

In fact, the media coverage ranged across a wide spectrum of attitudes. From the overtly prejudicial to those of sympathy. Other attitudes included concerns about the quality of care provided as well as fear for public safety. However others reports tended to have the opposite effect and depicted people with intellectual disability more in terms of ordinary human beings down on their luck.

One effect of deinstitutionalisation was an increased number and a more obvious presence of people with intellectual disability in the criminal courts and on the streets. Chapter 5 outlined comments by the judiciary and subsequently disseminated by the media recognising the precarious nature of living life on the outside of institutions for people who had been institutionalised over a long period of time. The media gave substantial coverage to the problems associated with deinstitutionalisation often using emotive language. Some of the coverage found its way into Ministry of Health files and caused an official response, either through questions in the House of Representatives or through press releases. The government responded to the concerns of interest groups.

One major point raised in chapter five was the common misidentification and the confusion abroad about the sameness of people with mental health issues and people who have an intellectual disability. People with intellectual disability are susceptible to mental ill health. However the confusion that occurred in the media, and commented upon in the Ministry of Health files, relates to the tendency to condense the two separate groups of people into one homogeneous whole, thereby adding to the lack of understanding by the public.

The history chapter observed that during the eugenic era the class of people depicted as 'mental defectives' included the mentally ill, the intellectually disabled, people with epilepsy and other groups of people with severe physical disabilities. Institutions cared for this composite group of 'defectives' as though they were one.

Though later separated the mentally ill and the intellectually disabled were often still held in psychiatric hospitals. Porirua Hospital held both

groups of people and this was referred to in newspaper articles regarding its closure. This misidentification of the mentally ill and the intellectually disabled also caused comment in the Ministry of Health files. The concern there was that the obvious dangerousness of a few mentally ill persons who killed others in large numbers was extended in the public mind to the intellectually disabled who did not commit such crimes.

This confusion of conditions is found in the Law Commission Report 30. Labelled as mental health issues it concerns very much the intellectually disabled and was initiated due to the actions of a man with intellectual disability. It is hardly surprising therefore that the media picked up and transferred the confusion to their audiences.

A cursory survey of press articles tended to confirm my suggestion that negative stereotyping by the media constituted one element of a moral panic, the depiction of a threat in simplistic form. Subsequently a more balanced consideration of the press coverage has revealed that other less stereotypical forms of reporting are also represented.

Press reporting usually begins with the receipt of information. In the area of intellectual disability the comments and opinions may come from experts and others involved in the field. As previously discussed many of the people closely involved were conceivably motivated by a mixture of desires and personal needs. People were pressuring the government for action unrelated to any panic. There were on one hand those who were genuinely concerned for the plight of the intellectually disabled while other, less sympathetic, motivating factors would not be voiced publicly. In dealings with the media such viewpoints would have been coloured by those interests, whatever those diverse interests included.

## **6.6 A swift intensification of public anxiety**

One further issue remains to be discussed here. Would the danger aspects in the media reports have panicked judges, family members, service providers and legal experts and led to a rapid build-up of public concern?

To distinguish whether there was a rapid build-up of anxiety during the years since the new mental health legislation was introduced in 1992 required confirmation from either the Ministry of Health files or from the media. The Ministry files did not show an awareness of such a build-up of anxiety on the part of the public. In fact the files showed that responses to media concern occurred mainly in the first four years after the 1992 law change. There was continuing media coverage but this did not show often in the Ministry files. Neither did the media coverage show a clear increase in reportage over that period of time. On occasion the press gave substantial coverage of particular cases or of a particular problem as in the numerous articles in 1995 regarding the community placement of many people from Porirua Hospital.

The review discloses highlighted concerns, which with media accompaniment caused an intensification of anxiety to occur. If the view that people with intellectual disability are seen in negatively stereotypical roles were accepted then the process of deinstitutionalisation would have caused a general increase in the level of public anxiety simply on the basis of their community presence. Specific increases in anxiety affected those groups of people directly involved with the intellectually disabled. Parents and family members suddenly confronted by a relative for whom they have increased responsibility and a decrease in support systems are one example.



Family members did become involved in interest groups and were reported in the media.

Service agencies were a second group with specific concerns. Supporting those with difficult behaviours was an expensive operation. For those people with intellectual disability whose behaviour is unacceptable in some sections of society their presence might be seen as an affront. With the ongoing process of deinstitutionalisation and the changes to mental health legislation service providers had to handle people with behaviours where before they could have sent them back to an institution, or had them committed to a mental health facility. Furthermore service practices, which included restraint and medication, were coming under the spotlight with regard to rights issues. Personnel of these agencies who were assaulted provided the media with a steady flow of material. Certainly people within human services became very concerned. Management had to provide increasing surveillance of a number of clients on a diminishing budget.

It led to the inevitable dumping of some people with difficult behaviours onto the criminal justice system.

The criminal justice system began to see more people with intellectual disability. Judges had their own difficulties caused by the change in mental health legislation. The people could not be sent back to the service agency. They did not want them. They could only be sent to a mental institution if the matter was very serious and often did so in spite of opposition received from psychiatric clinicians. A number of people were sent to prison, especially in 1993 and 1994 and these actions received media attention. The judges were in a quandary and the option of custodial care would have seemed an appropriate alternative.

There are indications that an intensification of attitudes occurred during the 1990s due to law changes, the process of bringing people into the community and media coverage that included a number of high profile cases. Combined with concerns of specific groups of people mentioned above this had much to do with the intensification.

The media was involved to a substantial degree and without continued media attention a build-up of concern would have been very unlikely. Press coverage of individual criminal cases with a common additional aspect of dangerousness and unpredictability provided high interest stories. The problems associated with deinstitutionalisation especially where residents of a particular locale did not want the intellectually disabled in their neighbourhood, the 'not in my backyard' concern, was and remains a perennial problem for service agencies. These concerns suggest that there was increasing anxiety among sections of the population. News articles helped raise the levels of fear of intellectually disabled people. It appears that, on the face of it, a moral panic did exist. Yet when the actual process of creating legislation is examined, see below, a single hypothesis does not seem to be a viable conclusion in the face of the data in chapter five.

### **6.7 A reaction from the authorities**

On October 5, 1999 the government introduced compulsory care legislation into parliament. Such a move constitutes a reaction to a perceived problem. The difficulty however is to establish whether this reaction was the result of a moral panic. The government did respond to pressure applied from different interest groups. The files show that the government listened to the judiciary and took notice of media coverage of serious offending by people with intellectual disability. The concerns of people in charge of institutions for the care of intellectually

disabled people were also taken into account. Were the pressure exerted on the government sufficient to amount to a moral panic?

If an examination of those pressures is undertaken in order to quantify the amount to determine sufficiency the task is likely to be inconclusive. However if the actions of government are viewed outside of any theoretical paradigm the answer in one respect becomes clearer.

From the very beginning the government proposed a legislative response, initially through an amendment to mental health legislation. Experts in law supported a legislative solution and were invited to provide material for the government to consider. The government appears to have then heeded the advice given by judges, the Law Commission and law academics.

On the other hand many experts in the field of intellectual disability counselled, at least in the beginning, against such a simplistic response. In fact, as already described in chapter five, when the advisory group argued against legislation they were informed that the Minister would direct that legislation be drafted. It may be concluded that pressure from some interest groups had little or no effect on the final outcome.

The government does not appear to have been railroaded. What seems most likely from the Ministry files is that the government listened to the judiciary and took particular notice of the Law Commission Report 30. In 1994 the Law Commission's Report, while stressing the need for adequate resources, asserted that legislation should be drafted which would include both the offender and non-offender groups of intellectually disabled people. The 1999 Bill follows this course. Why then the involvement of experts in the field of intellectual disability.

Cynicism might suggest that perhaps the government wanted to get service providers on side, as they had been vocal in their denunciation of the amendment to the mental health legislation and which was subsequently defeated. Or it may have been window dressing.

## **6.8 Conclusion**

If a moral panic was to run its course, at the point where the authorities reacted the panic would begin to recede or there would be social change. In the case of this legislation that might occur very quickly for the estimated number of people who would be subject to the legislation is more of a stock-take than an estimate. The likelihood is that those already identified would be quickly put through the process and would then fade from public sight. Whether the problem had been the result of a moral panic or simply a problem based in other sources would be irrelevant and perhaps difficult to discern. The problem would simply have been solved.

Previously mentioned was the awareness by the Ministry of Health that many of the problems associated with people with intellectual disability were human service generated. In plain speaking the service was at fault not the person. Yet this major issue was not addressed in the legislation. The legislation would compel people who have an intellectual disability to accept services and provides for punitive measures should they not comply. It is possible to speculate that this measure is simply a device to remove unwanted people. It never intended rehabilitation only containment. It provided a legal response based upon the advice of the judiciary to a social problem. What do we do with those who are difficult to care for? Lock them up!

## **Chapter Seven**

### **7.1 Conclusion**

The research was undertaken due to my personal involvement with people who would almost certainly be subject to compulsory care legislation should it have been passed. The people I support usually need support for a long time if they are to have any chance of being welcomed back into the wider community. Support in years is more common than in months or weeks. I get to know the people, their families and their supporters. Each one is an individual, not a member of some predetermined class or group. They are as different from each other as are all other people and they have in common the same needs as all other people. After learning their history's which includes stories of poor service and of abusive treatment over long periods of time I am often amazed that they have survived at all.

While supporting people I had begun to understand how differently they were treated by the criminal courts. In dealing with people who have intellectual disability judges show their tolerance or intolerance depending upon their own beliefs. Some worked diligently to bring about appropriate solutions to complicated situations. Other judges took the Pontious Pilate option and simply washed their hands of the problem. Lawyers, police and others involved in the judicial system demonstrated a broad range of responses, based upon personal beliefs, to people with intellectual disability. One of the ongoing difficulties was the problem of disposition. What to do. This lack of options for the courts almost always resulted in a poor outcome for the person adjudged.

So it was with a very personal interest that I undertook to find out more about the proposed legislation. I began research with a biased view. I was aware of history as it related to people with intellectual disability, the prejudice and the discrimination, which has been outlined in chapter four. I was suspicious of the motives of those proposing the legislation. Doing the research would perhaps provide an opportunity to get behind the scenes and to identify the impetus for it. The direction that the legislation took could affect for good or ill the lives of those I supported.

To undertake a thesis within an academic context requires a sociological theory to underpin the research. The paradigm of a moral panic seemed to be almost a perfect fit. With suspicions already aroused I approached the task expecting to find conclusive evidence of a moral panic. Initial data tended to support my supposition. I found newspapers articles that stereotyped people with intellectual disability. Comments by a law academic related in chapter five that politicians and the media were over reacting to the problem posed by intellectually disabled offenders also supported the hypothesis that a moral panic was in existence. Yet the further that I dove into the data the more I found that it could not be so easily explained. Moral panic did not have the explanatory power I had initially thought it would. The model of a moral panic could not be reshaped sufficiently in order to accommodate all of the conflicting data. For example one presumably powerful interest group, human service providers, were unable to prevent the government from embarking on the course of drafting stand-alone legislation. When they opposed it they were told simply that the Minister would direct that this course of action be followed. The government was not responding to pressure from this pressure group, as it should have done if a moral panic was in progress.

Even more compelling in defeating the notion of moral panic as the impetus for the legislation was the data from the Ministry of Health files that showed how closely the legislation has followed the recommendations of the Law Commission published in 1994. It seems that a likely scenario is that, notwithstanding all of the consultations, objections and pressures that have been applied during the intervening five years the government has followed the Law Commission's advice. Confirmation of this is in the Explanatory Notes to the Bill. The Law Commission's recommendations are mentioned and used as justification for the legislative form.

The paradigm of a moral panic then did not fit the data, as it was unearthed. However it would have been dishonest to attempt to twist the information gleaned to suit the hypothesis. As mentioned in chapter three by Frost and Stablein (1992) doing research is messier than expected and in the process the researcher may uncover unexpected information leading to conclusions other than were expected.

Nevertheless the academic finding that a moral panic does not fit all the facts is almost irrelevant. The impetus for my involvement in this particular research was caused by a deep concern about the things that were being done to people I worked with, people who were always individuals and who sometimes became friends. Whatever the impetus, the legislation is in my view harsh and will do absolutely nothing to enhance the long term living prospects of the people who will be subject to it.

On October 5, 1999 the New Zealand Government introduced the 'Intellectual Disability (Compulsory Care) Bill'. The process that led to this legislation being brought to parliament has been the basis of this

research. As already clarified my position has been, and remains, one of opposition to this legislation.

In all but one respect little about the Bill has changed over the five years since stand-alone legislation was mooted to alter this opposition. The change has concerned the inclusion of children with intellectual disability into the Bill at a very late stage in the Bill's development. Such an inclusion has led to an increase in opposition to the legislation, but perhaps for the wrong reason. Newspaper articles in August, when that information was leaked to the press, reported a number of denunciations of the legislation. Not on the grounds that the Bill was wrong but on the grounds that children were included.

The real concern as I see it is that if the criteria can be widened to include other groups of people then expediency will dictate that this occur. There are many people who have disabilities which give rise to involvement with the law and create difficulties for service providers. The concern is that they too will sooner or later be included.

As chapter five showed the inclusion of the civil population, that is people who have an intellectual disability and are considered dangerous but have not been charged with a crime was finally included late in 1997 or early 1998. As Dawson argued in his report on the shape of the legislation, its use will be expanded. More people will be subjected to the legislation than is the currently expected.

If not stopped the legislation will be passed in the year 2000. The legislation does not constitute progress in terms of human rights or the dignity and worth of the individual. It is a backward step. It will introduce to a new century and new millennium ideas attitudes and values better left behind.



## 7.2 Epilogue

In an East Auckland local newspaper there is a story of an 'Autistic Centre ready for children'. It is described as a New Zealand first. It seems that a primary school renovated to old schoolrooms and turned them into one 'unit'. The unit has, in addition to two timeout rooms, an enclosed play area and the school now has a higher fence. Sufficient funds were provided for the fencing and the timeout rooms but the communication equipment needed to teach the children was not made available. That money will have to be found through sponsorship. The article is infused with a quiet pride in the achievement. It is a new way forward.

I hear only alarm bells sounding a very strident warning. Somewhere between normalising the lives of people with intellectual disability and the end of the century New Zealand society appears to have taken a wrong turning. New Zealand society seems to be heading back towards more simplistic solutions without care or understanding of the pain that will again be visited upon a disadvantaged and devalued section of our population. Is the proposed legislation simply that easy, out of sight out of mind answer to a complex problem or does the Intellectual Disability (Compulsory Care) Bill reflect a darker attitude of prejudice on the part of many in the general population towards people who have an intellectual disability?

## Appendix A

### INTELLECTUAL DISABILITY (COMPULSORY CARE) BILL

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#### EXPLANATORY NOTE

##### *General Policy Statement*

This Bill sets out the limits that can be imposed on the freedoms of people who have an intellectual disability and who are in need of compulsory care, by requiring them to accept care programmes. The Bill also provides a framework for protecting the rights of individuals subject to the Bill.

##### *Persons Subject to the Bill*

The Bill has been developed for the compulsory care of individuals with an intellectual disability—

- Who are charged with an imprisonable offence and found guilty or unfit to stand trial or acquitted on the grounds of insanity (offender group); and
- Whose behaviour poses a serious risk of danger to themselves or others, although they have not been charged with an offence, and who will not voluntarily access the care and support services needed for their own or others' protection (non-offender group).

There are 3 main sub-groups of the non-offender group:

- Those with a mild intellectual disability, generally indicated by an IQ of 50–70 and a serious social disability, who will not voluntarily attend services or receive care. They are generally young males who have become known to service providers, the community, and police because of their behaviour in the community;
- Those with a moderate intellectual disability, generally indicated by an IQ of 30–50 and communication problems who may sometimes become frustrated and express this in violent behaviour;
- Those who are profoundly disabled who injure themselves.

It is estimated that the Bill will cover, at any one time, around 200 adults, children, and young people with an intellectual disability who require compulsion to access services that provide the necessary care, support, and protection that they need.

For the non-offender group, the Bill is an intervention of last resort when there is no other alternative to meet the person's care and safety needs or to protect others. To reinforce these principles, persons in the non-offender group are

considered to be in need of compulsory care only if the person exhibits behaviour—

- That poses a serious danger to the health or safety of that person or of others; and
- That cannot be effectively managed without the compulsory powers of this Bill.

For the offender group, the Bill provides more appropriate disposition options than are currently available. These options are detention as either a special care recipient or a civil care recipient. Special care recipient status is designed for persons who would otherwise have been imprisoned and for whom a court wishes to apply the most restrictive powers available under this Bill. The duration of a special care recipient order is set by the *Criminal Justice Amendment Bill (No. 7)* and parallels those for persons given special patient orders by the court under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Civil care recipient status allows the options of secure care or supervised care (which may be in a residential facility or at a non-residential community placement) with the emphasis on placing the person in the least restrictive environment commensurate with keeping themselves and others safe. A compulsory care order for a civil care recipient is for a maximum of 3 years. These can be renewed, but compulsory care orders can also be revoked if a six-monthly assessment recommends that the person is no longer in need of compulsory care. Persons who have not offended are all civil care recipients.

#### *Need for Compulsory Care Powers*

Persons with an intellectual disability were included in the definition of “mental disorder” in the Mental Health Act 1969, which was later linked to the Criminal Justice Act 1985. However, the Mental Health (Compulsory Assessment and Treatment) Act 1992 deliberately excluded persons with an intellectual disability (unless they also have a mental disorder). This is because intellectual disability is now seen as a learning disability that results in substantial limitations in functioning. Unlike a mental illness, it cannot be treated. It is therefore inappropriate for persons with an intellectual disability to be subject to an order requiring them to undertake treatment.

This exclusion created a legislative gap, for the offender group, between the Mental Health (Compulsory Assessment and Treatment) Act 1992 and Part VII of the Criminal Justice Act 1985, resulting in limited options being available to the courts for dealing with persons with an intellectual disability who are charged with or convicted of an imprisonable offence. This has sometimes resulted in inappropriate placement in prison, mental health services, or discharge into the community. This Bill links with the *Criminal Justice Amendment Bill (No. 7)* to enable criminal courts to impose appropriate orders for people with an intellectual disability.

There is currently no unequivocal legislation that allows for the assessment and compulsory care of persons in the non-offender group, in order to manage serious risk of danger to themselves or others. The risks cannot currently be managed by non-legislative processes if the person refuses to access services to manage or contain these behaviours.

The inclusion of persons with an intellectual disability who have not been charged with an offence is consistent with recommendations made in the Law Commission Report *Community Safety: Mental Health and Criminal Justice Issues* (August 1994). One of the Law Commission’s terms of reference was the right of members of the community to be protected from physical harm inflicted by others. In respect of this the Law Commission recommended the preparation of new legislation for persons with an intellectual disability who present a substantial risk of danger to themselves or others.

The Bill also applies to children and young persons who meet the criteria for intellectual disability and require long-term compulsory care because of behaviour which poses a serious danger to the health or safety of the child or young person or of others, if that behaviour cannot be managed without relying on the Bill. Currently, persons with an intellectual disability under the age of 17 years are subject to the Children, Young Persons, and Their Families Act 1989. The Children, Young Persons, and Their Families Agency has limited options for providing appropriate services for children and young persons with an intellectual disability and whose behaviour poses a serious risk of danger to themselves or others. Currently, a small number (approximately 5) of such children and young persons are inappropriately placed in Department of Social Welfare residences with others who do not have an intellectual disability. This mix can exacerbate behaviour problems for both groups. Children and young persons with an intellectual disability who are in need of compulsory care are more likely to respond to specialist services tailored to their particular needs.

It is envisaged that children and young persons in need of short-term care can be managed under the Children, Young Persons and their Families Act 1989.

The terms "child" and "young person" have the same meaning as in the Children, Young Persons, and Their Families Act 1989 and refer to persons under the age of 17 years. This congruence is to reinforce the Bill's status as legislation of last resort, to be used only if a child or young person's care and protection needs cannot be met under the provisions of the Children, Young Persons, and Their Families Act 1989. The Bill contains special provisions that safeguard the rights of children and young persons who come under the Bill.

#### *Exclusions*

The Bill does not apply to—

- Persons whose intellectual impairment has been caused by some event after the developmental period (18 years or older);
- Persons who are specifically covered by the Mental Health (Compulsory Assessment and Treatment) Act 1992, for example, adults who have a mental disorder without intellectual disability or have an acquired brain injury. Compulsory assessment and treatment for adults who exhibit disturbed behaviour as the consequence of an acquired brain injury are covered by the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992;
- Persons with a personality disorder without intellectual disability.

Personality disorder is a poorly defined and frequently misused clinical concept, which describes patterns of persistently abnormal behaviours that are the 'norm' for the individual, rather than an illness. Persons with a personality disorder for whom compulsory assessment and treatment is required should be dealt with under the Mental Health (Compulsory Assessment and Treatment) Act 1992, or by criminal justice processes if they are not mentally disordered. The Law Commission, in its 1994 report *Community Safety: Mental Health and Criminal Justice Issues*, recommended no change in legislation with respect to those with a personality disorder.

#### *Principles Underlying the Provision of Compulsory Care*

The principles underlying the development of the provisions of the Bill for civil care recipients aim to balance care and support needs with protection of safety. The key principles are that—

- A compulsory care order is an option of last resort that is used only when other support or care arrangements are insufficient to prevent the person's behaviour posing a serious danger to themselves or others:

- Every care recipient should receive care that protects—
  - (a) The health and safety of the care recipient and of others; and
  - (b) The rights of the care recipient.

The above principles also apply to special care recipients to the extent that they are compatible with the provisions of their specific court orders.

There are additional principles relating to children and young persons (under 17 years) subject to compulsory care that recognise their special vulnerability.

These include:

- The welfare and interests of the child and young person must be the paramount consideration:
- The child or young person should not become subject to a compulsory care order unless the child or young person requires long-term compulsory care:
- The family, whanau, hapu, iwi, and family group should participate in decisions affecting the child or young person:
- The child or young person's links with the family, whanau, hapu, iwi, and family group should be maintained and strengthened:
- Decisions affecting a child or young person may be taken only after consideration of the likely impact on the welfare of the child or young person and on the stability of the family group:
- The wishes of the child or young person should be considered:
- Powers under the Bill may be exercised only after attempts to obtain the support of the child or young person, their parents or guardians or principal caregivers:
- Decisions should be taken within a time-frame that matches the sense of time of the child or young person.

#### *Key Administrative Roles*

The framework for administering compulsory care has been modelled on that for administering the Mental Health (Compulsory Assessment and Treatment) Act 1992, but has been simplified where possible to reflect the smaller and more stable population who would be subject to compulsory care. Three new roles are introduced as part of the compulsory care regime—specialist assessor, compulsory care co-ordinator, and care manager. In addition, the role of District Inspector under the Mental Health (Compulsory Assessment and Treatment) Act 1992 is extended to include functions under this Bill.

Compulsory care co-ordinators are the top level administrators in the compulsory care regime. They are responsible for processing applications and for organising assessments; diverting persons subject to an application to appropriate alternative services wherever possible; where diversion is not possible, they are responsible for ensuring that a needs assessment and care plan are developed; applying for a court order for compulsory care; and liaising with the court regarding changes to a compulsory care order. There will be a small number of compulsory care co-ordinators, who will be approved by the Director-General of Health.

Specialist assessors are health or disability professionals with expertise in intellectual disability who have been approved by the Director-General of Health. They undertake the assessment of whether the person has an intellectual disability as defined by this Bill and is in need of compulsory care.

Care managers are responsible for designing the individual packages of care tailored to meet the person's needs. Care managers are also responsible for implementing the care plan and for ongoing support and monitoring of the person's care.

District Inspectors will perform a parallel function to their role under the Mental Health (Compulsory Assessment and Treatment) Act 1992, by providing an independent monitoring function to ensure that persons under a compulsory care order or detained as a special care recipient have their legal rights upheld.

#### *Process for Entry to Compulsory Care*

The process for entering compulsory care balances the rights of others to protection of their safety with the rights of the individual not to be arbitrarily detained or have their liberty restricted without good reason.

Anyone aged 18 or over can apply to a Compulsory care co-ordinator for an assessment under the Bill. This allows for others to be protected from harm. In order to safeguard the individual's rights against arbitrary detention, the application must be supported by a certificate issued by a registered medical practitioner or a registered psychologist.

For the offender group, the criminal courts can order an assessment. A prison manager can also apply to a compulsory care co-ordinator for an assessment of an inmate.

The first assessment is a special assessment to determine whether the person meets the entry criteria for compulsory care or special care recipient status.

#### *Criteria for Entry to Compulsory Care*

For the non-offender group, there are 3 criteria that have to be met for entry to compulsory care:

- They have an intellectual disability as defined in the Bill; and
- Their behaviour poses a serious risk of danger to themselves or others; and
- There is no alternative to compulsory care.

These criteria are designed to limit application of the Bill to the option of last resort.

#### *Definition of "Intellectual Disability" and Statement of Serious Risk of Danger*

For the purposes of the Bill, intellectual disability is defined as a permanent impairment that results in significantly sub-average general intelligence (usually indicated by an IQ of 70 or less) and in significant deficits in at least 2 of the following skills: communication; self care; home living; social skills; use of community services; self direction; health and safety; reading, writing, and arithmetic; leisure; and work. The impairment must also become apparent during the developmental period of the person's life. The terms used in this definition have specialist meanings accepted by clinicians. The definition is based on one developed by the American Association for Mental Retardation and published in 1992.

That definition is accompanied by 4 assumptions, which are essential to the application of the definition:

- Valid assessment considers cultural and linguistic diversity as well as differences in communication and behavioural factors:
- The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualised needs for support:
- Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities:
- With appropriate supports over a sustained period, the life functioning of a person with intellectual disability will generally improve.

The concept of risk of danger is the same as risk of dangerousness under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Assessment of

the risk of danger should balance the imminence, seriousness, and likelihood of harm occurring to the health or safety of the person or others.

Persons will be clinically assessed on an individual basis by appropriately qualified specialist assessors with expertise in intellectual disability. In the case of children and young persons, the specialist assessor should have expertise in assessing children with intellectual disability.

The compulsory care co-ordinator initiates an assessment which includes:

- Whether the proposed care recipient has an intellectual disability; and
- Whether the proposed care recipient needs compulsory care; and
- The level of care required to manage the risk(s) associated with the person's behaviour.

This is designed to take account of the person's care and support needs as well as protecting safety. Only when the care needs assessment and the care programme have been developed can a compulsory care co-ordinator apply to the court for a compulsory care order.

For the offender group, the main objective is to ensure that appropriate placement options are available for persons with an intellectual disability who have been sentenced to a period of detention, found unfit to stand trial, or acquitted on the grounds of insanity. The criteria for entry for the offender group are that they have a mental impairment. Under the *Criminal Justice Amendment Bill (No. 7)*, mental impairment is intended to capture both mental disorder for entry to the Mental Health (Compulsory Assessment and Treatment) Act 1992 and intellectual disability for entry to this Bill. Mental impairment is left undefined in the *Criminal Justice Amendment Bill (No. 7)* so that the courts are free to interpret the term in line with the overall purpose of ensuring procedural fairness. It is envisaged that, following a court order under this Bill, the individual concerned will be referred to a Compulsory care co-ordinator for a care needs assessment and the development of a care plan.

#### *Relationship with Generic Support Services for People with Disabilities*

Persons subject to the provisions of this Bill will generally already be clients of Health Funding Authority funded disability support services. The assessment and care of persons with intellectual disability under this Bill is consistent with the key steps in the framework for disability support service delivery (DSS framework). These are:

- Needs assessment to identify what a person needs to achieve independence and participate fully in society, according to their abilities, resources, and goals;
- Service co-ordination to identify the package of services required to meet a person's needs, determine which needs can be met from publicly funded services, and explore options for addressing other needs; and
- Provision of care and support services.

Care orders made by the court will specify the purpose, duration, level of care required, security and monitoring procedures. These will form part of the overall care plan required to meet the needs of the care recipient.

#### *Statutory Powers*

The Bill contains a number of statutory powers of compulsion to require care recipients to comply with their care order. These include the requirement that the care recipient accept properly given care and comply with every lawful direction given by the care recipient's compulsory care co-ordinator or care manager.

There are provisions for specified people to use reasonable force to restrain, detain, or transport any person subject to either a care order or an application for assessment. There are also powers to seclude, restrain, and medicate care recipients under certain limited and defined circumstances.

### *Safeguards*

The above powers are balanced by specific safeguards against their abuse, including:

- A court review of the terms and conditions of a compulsory care order 6 months after its commencement;
- Six-monthly clinical reviews of the care order;
- Independent monitoring of the care order by a district inspector;
- A High Court Judge may inquire into any matters relating to a person under this Bill as the Judge thinks fit.

### *Care Recipient Rights*

In addition to the above safeguards, the Bill provides for specific care recipient rights, including the right to:

- Information relating to an assessment or care order and their rights in a form that the care recipient is most likely to understand;
- Respect for the care recipient's cultural identity;
- Independent health and disability advice and legal advice;
- Company, to receive visitors, and to receive and send mail.

District inspectors will have a role in ensuring these rights are respected. Care recipients under the Bill also continue to have all the rights of a consumer under the Code of Health and Disability Services Consumer Rights.

### *Release from Care Orders*

Only the courts may release a person from a compulsory care order. This is unlike the Mental Health (Compulsory Assessment and Treatment) Act 1992, where a responsible clinician or a review tribunal or the courts may release a person from an order. The difference in requirements reflects the difference between the objectives of the Mental Health (Compulsory Assessment and Treatment) Act 1992, which are assessment and treatment, and those of this Bill, which focus on care and safety issues for persons with an intellectual disability.

A special care recipient is released from that care order under the following conditions:

- If the special care recipient is also subject to a sentence of imprisonment, when the sentence ceases to run, at which point he or she becomes a civil care recipient;
- The Attorney-General or the Minister of Health has approved a change in legal status to that of civil care recipient.

A civil care recipient is released from compulsory care under the following conditions:

- The expiry of the court order, if no extension is sought; or
- A Family Court decision following a request from a compulsory care co-ordinator for a cancellation of the order.

### *Clause by Clause Analysis*

*Clause 1* relates to the Short Title and the commencement of the Bill. The Bill will come into force on a date or dates to be appointed by Order in Council. This is necessary because the operation of the Bill depends on the enactment of the *Criminal Justice Amendment Bill (No. 7)*, and also on prior administrative arrangements.



PART 1  
OUTLINE OF THIS ACT

*Clause 2 to 16* provide signposts to help readers navigate their way through the Bill.

PART 2  
PRELIMINARY PROVISIONS  
SUBPART 1—DEFINITIONS AND KEY TERMS

*Clause 17* sets out the defined terms used in the Bill.

*Clause 18* defines the terms “care recipient”, “civil care recipient”, “special care recipient”, and “proposed care recipient”. “Care recipient” is a general term of broad application. Thus a care recipient may be any person who has, or is believed to have, an intellectual disability and to be in need of compulsory care. The basic distinction between civil care recipients and special care recipients is that special care recipients are subject to greater restrictions. Generally speaking, civil care recipients will acquire their status through a civil route, that is by an order of the Family Court. Special care recipients, on the other hand, acquire their status in connection with a criminal charge or conviction. The term “care recipient” also includes a “proposed care recipient”, that is a person who is being assessed under the Bill or for whom a compulsory care order is sought in the Family Court.

*Clause 19* defines the expression “in need of compulsory care”. To be in need of compulsory care, a person must behave in a way that poses a serious danger to his or her health or safety or to the health or safety of others; and the person’s behaviour must be such that it cannot be effectively managed without the support of the Bill.

*Clause 20* defines the term “intellectually disability”. A person has an intellectual disability if the person has a permanent impairment that results in significantly sub-average general intelligence and in significant deficits in at least 2 of the skills listed in *subclause (3)*. An intelligence quotient of 70 or less is indicative of significantly sub-average general intelligence.

*Clause 21* provides that a person does not have an intellectual disability simply because the person has a mental disorder within the meaning of the Mental Health (Compulsory Assessment and Treatment) Act 1992. Nor does a person have an intellectual disability simply because the person does not feel shame or remorse about harm the person causes to others (a condition sometimes referred to as a personality disorder).

*Clause 22* defines the terms “facility” and “secure facility”. A facility is any place used by a service to provide care to persons with an intellectual disability. A secure facility is a facility that is designed or operated to stop residents from escaping. A prison cannot be a facility.

SUBPART 2—APPLICATION TO CROWN

*Clause 23* provides that the Bill binds the Crown.

PART 3  
OBJECTS, PRINCIPLES, AND GENERAL DUTIES

*Clause 24* sets out the objects of the Bill. These are, first, to provide protection from any serious harm that persons who have an intellectual disability and are in need of compulsory care may do to their health and safety and that of others; secondly, to recognise and safeguard the special rights of persons subject to the

Bill; and, thirdly, to provide for the appropriate use of different levels of care for individuals subject to the Bill.

*Clause 25* sets out 2 principles by which courts and persons exercising powers under the Bill must be guided. First, a compulsory care order is a measure of last resort (but this provision does not apply to inmates). Second, every care recipient should receive care that protects the health and safety of the care recipient and of others, and that also protects the rights of the care recipient.

*Clause 26* sets out further principles that must guide courts and persons whenever they exercise powers under the Bill in respect of children and young persons. The principles are that the welfare and interests of the child or young person must be the paramount consideration; that the child or young person should not become subject to a compulsory care order unless the child or young person requires long-term compulsory care; that the family and wider family group should participate in decisions affecting the child or young person; that the links of the child or young person to his or her family and wider family group should be maintained and strengthened; that the impact of each decision on the welfare of the child or young person and on the stability of the family and wider family group must be considered; that the wishes of the child or young person should be considered; that powers over a child or young person should be exercised only after attempts to obtain the support of the parents or guardians or principal caregivers of the child or young person, and of the child or young person himself or herself; that decisions should be taken within a time-frame that matches the sense of time of the child or young person. To the extent of any inconsistency, the principle, set out in *clause 25 (2)*, that a compulsory care order is a measure of last resort prevails over the principles set out in this clause.

*Clause 27* sets out the way in which care recipients must be treated in proceedings under the Bill, and when powers are exercised over them. Courts or persons exercising authority must recognise the importance and significance of the mutual relationship between the care recipient and his or her family and wider family group, and act with respect for the care recipient's cultural and ethnic identity. Proper respect must also be shown for the competencies and autonomy of the care recipient by keeping all procedures, so far as possible, within the care recipient's power of understanding.

*Clause 28* relates to the provision of interpreters for care recipients. If it is practicable to do so, an interpreter must be provided when a care recipient needs one in proceedings under the Bill, or when a power is exercised over the care recipient, or when the care recipient is informed of a matter in accordance with the Bill. A care recipient may need an interpreter if the care recipient is able to understand something only if it is expressed in less complex terms or in another medium.

## PART 4

### ASSESSMENTS

#### SUBPART 1—ASSESSMENT TO ASCERTAIN IF PROPOSED CARE RECIPIENT HAS AN INTELLECTUAL DISABILITY AND IS IN NEED OF COMPULSORY CARE

*Clause 29* provides for the assessment of persons believed to have an intellectual disability and to be in need of compulsory care. Applications are made to the Co-ordinator. Applicants must be 18 years or over.

*Clause 30* provides for the matters to be stated in an application under *clause 29*.

*Clause 31* requires every application under *clause 29* to be supported by the certificate of a medical practitioner or a psychologist, who may not be related to the applicant. The certificate must state that the medical practitioner or psychologist has examined the person to be assessed within the 3 days immediately before the date of the application, and that there are reasonable grounds for believing that the person to be assessed may have an intellectual disability and be in need of compulsory care.

*Clause 32* provides that if an application under *clause 29* is properly made, the Co-ordinator must initiate the assessment sought by the application. However, no assessment may take place if the person to be assessed has recently been assessed, and there is no reason for believing that the circumstances of the person have changed. In urgent cases where a person has been examined by a medical practitioner or psychologist who has given a certificate under *clause 31*, the Co-ordinator may initiate an assessment without an application.

*Clause 33* provides that when the assessment of a care recipient commences, the Co-ordinator must designate a care manager for the care recipient. Provision is also made for the arrangements that have to be made for an assessment, particularly for the designation of the specialist assessors who are to conduct the assessment.

*Clause 34* bars the medical practitioner or psychologist who gave the certificate in support of assessing a person from acting as a specialist assessor in the conduct of the assessment.

*Clause 35* relates to the assessment of a child or young person. If practicable, a specialist assessor who practises in the field of child or adolescent disability must be involved in the assessment.

*Clause 36* requires the Co-ordinator to notify the proposed care recipient, and specified persons concerned with the care recipient's care and welfare, of the forthcoming assessment. This must be in writing and in a form that the proposed care recipient is most likely to understand.

*Clause 37* requires the Co-ordinator to explain the purpose of the examination to the proposed care recipient in the presence of a guardian or the care recipient's principal caregiver. The Co-ordinator must then find out if the proposed care recipient (or his or her guardian) agrees to attend the assessment examination. Except in the case of an emergency, the proposed care recipient or guardian must be given at least 48 hours to consider whether to consent to the examination. If consent is not given, the Co-ordinator must consider the desirability of applying to the Family Court for an interim order under *Subpart 3*.

*Clause 38* provides that the designated specialist assessor must conduct an assessment examination to ascertain whether the proposed care recipient has an intellectual disability and is in need of compulsory care. If that is the case, the specialist assessor must assess the level of care that is required to manage the risk that the care recipient's behaviour poses to the health and safety of the care recipient or of others. The specialist assessor must consult with specified persons concerned with the care recipient's care and welfare and with the care recipient's family or whanau about the proposed care recipient's condition and background (except where consultation is not practicable).

*Clause 39* deals with the situation where the specialist assessors cannot form a conclusion on the basis of a single examination. The assessors must advise whether the proposed care recipient will need to stay in a facility to complete the

assessment. If a proposed care recipient (or the care recipient's guardian) does not consent to stay in a facility after being advised to do so, the Co-ordinator must consider the desirability of applying under *Subpart 3* to the Family Court for an interim order.

*Clause 40* requires an assessment under *Subpart 1*, that is the first phase of an assessment, to be completed as quickly as practicable, and, in any case, within 30 days.

*Clause 41* requires a specialist assessor, on finishing the assessment of a proposed care recipient, to set out in a report to the Co-ordinator whether the proposed care recipient has been assessed as having an intellectual disability and as being in need of compulsory care.

*Clause 42* provides that, if the report under *clause 41* does not indicate that the care recipient has an intellectual disability and is in need of compulsory care, the Co-ordinator must immediately ensure that the person is released. The Co-ordinator must also take steps to ensure that the person is provided with reasonable assistance to re-enter the community.

*Clause 43* provides that, as soon as a proposed care recipient has been assessed as having an intellectual disability and as being in need of compulsory care, the Co-ordinator must initiate an assessment of the care needs of the proposed care recipient.

#### SUBPART 2—ASSESSMENT OF CARE NEEDS

*Clause 44* sets out the purpose of a needs assessment, namely to assess the kind of care that the proposed care recipient needs, and to prepare a care plan for the care recipient.

*Clause 45* requires the Co-ordinator to start the needs assessment process by explaining the proposed care recipient's condition and the purpose of the needs assessment to the proposed care recipient, and to persons concerned with his or her welfare.

*Clause 46* requires every needs assessment process to be completed as quickly as practicable. In no case may a needs assessment process continue for longer than 30 days.

*Clause 47* requires the Co-ordinator to consult the specialist assessor who assessed the care recipient's condition, and also the care recipient's care manager.

*Clause 48* requires the Co-ordinator to make all reasonable efforts to consult with members of the proposed care recipient's family or whanau and others concerned with the welfare of the care recipient. One of the purposes of the consultation is to ascertain the level of support for the proposed care recipient in the community.

*Clause 49* provides that the Co-ordinator may consult interested parties by holding a case conference.

*Clause 50* requires every needs assessment to include a cultural assessment. If the proposed care recipient is Maori, the Co-ordinator must try to obtain the views of Maori organisations concerned with the care of persons who have an intellectual disability.

*Clause 51* requires the Co-ordinator to consider whether it is practicable to make arrangements for the support and care of the proposed care recipient without a compulsory care order.

*Clause 52* provides that, when the kind of care a proposed care recipient needs has been assessed and a service provider that can provide that care has been identified, the Co-ordinator must decide whether to apply for a compulsory care order. The decision must be notified to the proposed care recipient and to specified persons concerned with his or her care and welfare.

*Clause 53* deals with the case where the Co-ordinator decides not to apply for a compulsory care order in respect of a proposed care recipient, and gives the person who applied for the proposed care recipient's assessment a right to challenge that decision before the Family Court. That Court may direct the Co-ordinator to reconsider his or her decision.

*Clauses 54 to 57* deal with the preparation of care plans. When the Co-ordinator decides to apply for a compulsory care order, the care manager must arrange for the preparation of a care plan. A care plan needs to be approved by the Co-ordinator. Every care plan must identify the personal needs of the care recipient, including any required medical or psychological treatment, and the care recipient's propensity for dangerous behaviour. The plan must indicate how the care recipient's needs can be met. It must also contain a care programme setting out specified matters, including the objectives of the care, and the degree of security required for the care of the care recipient. If it is proposed that the care recipient receive supervised care (as opposed to secure care), the care plan may specify the persons with whom the care recipient may be required to live.

#### SUBPART 3—INTERIM ORDER BY FAMILY COURT IN RESPECT OF PROPOSED CARE RECIPIENTS

*Clause 58* gives the Family Court jurisdiction to make an interim order requiring a proposed care recipient to stay in a facility while the care recipient is being assessed. The Court must be satisfied that the care recipient has been assessed as having an intellectual disability and as being in need of compulsory care, or that it is highly probable that the care recipient has an intellectual disability and is in need of compulsory care. Further, the Court must be satisfied that it would be impractical or unsafe to conduct or continue the assessment without requiring the proposed care recipient to stay in a facility, and that that requirement is in the interests of the proposed care recipient or in the public interest. The Family Court may also make an interim order for a proposed care recipient while an application for a compulsory care order is pending for the care recipient. The Court must be satisfied that there is a real risk that the proposed care recipient will harm himself or herself or others if he or she does not stay in a facility while the application is pending.

*Clause 59* provides that the Co-ordinator may apply for an interim order under *clause 58* without notice. The supporting documentation must include a certificate by the responsible district inspector that the application is properly made.

*Clause 60* sets out the persons on whom an application for an interim order must be served.

*Clause 61* allows every person entitled to be served with an application for an interim order to apply to the Family Court to have an interim order cancelled or varied. The Co-ordinator may apply at any time without notice for the cancellation of the order.

*Clause 62* sets out how long an interim order lasts. An interim order expires if the proposed care recipient's assessment does not indicate that he or she has an intellectual disability and is in need of compulsory care, or if 3 days have elapsed since the completion of the needs assessment without the Co-ordinator applying

for a compulsory care order for the proposed care recipient, or if the needs assessment has not been completed within 30 days, or if the application for a compulsory care order for the proposed care recipient is disposed of or withdrawn.

#### SUBPART 4—ASSESSMENTS OF INMATES

*Clause 63* allows the superintendent of a prison to apply for the assessment of an inmate under *Subpart 1*.

*Clauses 64 to 67* provide for the assessment of inmates. An assessment examination must take place in the prison within 48 hours after the receipt of the application or if that is not practicable, in a facility within 72 hours after the receipt of the application. The clauses make provision for taking inmates between prisons and facilities, and also for stays in facilities, if that is required by a notice given by the Co-ordinator. Until that notice is given, a inmate remains in the legal custody of the superintendent of the prison. The fact that an inmate is required to stay in a facility does not prevent the inmate from being taken to court for any criminal proceedings against the inmate.

### PART 5

#### COMPULSORY CARE ORDERS

##### SUBPART 1—COMPULSORY CARE ORDERS

*Clause 68* deals with applications for compulsory care orders (which can only be made by the Co-ordinator). The Co-ordinator must support an application by an affidavit that sets out why the proposed care recipient has an intellectual disability and is in need of compulsory care; and the kind of care the proposed care recipient will receive to meet his or her individual needs, and to address the risk that his or her behaviour poses.

*Clause 69* provides that a Family Court Judge must examine the proposed care recipient as soon as practicable and in no case later than 14 days after the application for a compulsory care order is filed. The Judge's examination includes a discussion of the proposed care recipient's current situation and the effects that a compulsory care order would have on that situation.

*Clause 70* provides that, if the visiting Judge is satisfied that the proposed care recipient does not require a compulsory care order, the Judge may order the Co-ordinator to withdraw the application for the compulsory care order, and may cancel any interim order under *clause 58*.

*Clause 71* provides that the visiting Judge must, wherever possible, hear the application for a compulsory care order for the proposed care recipient. That application may not be heard unless the proposed care recipient has been visited by a Judge. The visiting Judge may hear the application immediately after examining the proposed care recipient.

*Clause 72* provides that the Court must cancel an interim order if the Court does not consider that the proposed care recipient has an intellectual disability and is in need of compulsory care. But if the Court considers that this is the case, the Court must determine whether or not it is necessary to make a compulsory care order.

*Clause 73* gives the Family Court jurisdiction to make a compulsory care order. That order can be made only if the Co-ordinator applies for it, and if the Court is satisfied that: the proposed care recipient has an intellectual disability and is in need of compulsory care; has been assessed under *Part 4*; is to receive, under a completed care programme, a programme of care that meets the individual needs

of the proposed care recipient, and addresses the risk that the proposed care recipient's behaviour poses. If the Court considers that the care programme does not meet those requirements, it may vary the care programme or direct that it be varied.

*Clause 74* provides that a compulsory care order for a civil care recipient must state whether the care recipient must receive supervised care or secure care. Secure care takes place in a secure facility. Supervised care may take place in a facility that is not a secure facility, or in some other place designated by the Co-ordinator. It is possible for the care recipient's own home to be designated as such a place.

A civil care recipient who requires residential care must be cared for in an "ordinary" facility, rather than a secure facility, if he or she can be appropriately placed in an ordinary facility, and the Court does not consider that care for the care recipient outside a secure facility would pose a serious danger.

*Clause 75* provides a maximum term of 3 years for a compulsory care order. The term of an order may be extended under *clause 115*.

*Clause 76* allows the Co-ordinator, after consultation with a care recipient's care manager, to apply to the Family Court for a variation of the care recipient's compulsory care order.

*Clause 77* authorises the Co-ordinator and the responsible care manager of the care recipient to vary the care recipient's care plan. However, no variation may be inconsistent with the court order, and any variation of the care programme requires the approval of the Family Court.

#### SUBPART 2—REVIEW OF COMPULSORY CARE ORDER AND PROGRAMME BY FAMILY COURT

*Clauses 78 and 79* require the Co-ordinator to report to the Family Court on the continued appropriateness of the terms of a care recipient's court order and care plan, and to send copies of the report to specified persons concerned with the care recipient's care and welfare. The report must be submitted 6 months after the date of the order (except where the order is for not more than 6 months, in which case the due date is 2 months after the date of the order). The report must be accompanied by a copy of the most recent certificate as to the care recipient's condition.

*Clauses 80 to 82* deal with the Family Court's review of the contents of a care recipient's court order and the care programme. The Court may call for reports from the Co-ordinator, the care recipient's care manager, the responsible district inspector, or any specialist assessor, and may require any of those persons to testify. On concluding a review, the Family Court may make recommendations to the Director-General of Health or to the Co-ordinator or to the care manager.

### PART 6

#### STATUS AND RIGHTS OF CARE RECIPIENTS

##### SUBPART 1—GENERAL STATUS AND SPECIFIC RIGHTS

*Clause 83* provides that every care recipient is cared for by a care manager designated by the responsible Co-ordinator. The care recipient is required to accept properly given care, and must comply with every lawful direction given by the care recipient's Co-ordinator or care manager.

*Clause 84* provides that a care recipient under the Bill has all the rights of a consumer under the Code of Health and Disability Services Consumers' Rights.

*Clause 85* provides for the information to be given to a care recipient when the care recipient becomes the subject of a court order. The care recipient's care manager must keep the care recipient informed about the care recipient's rights.

*Clause 86* requires every care recipient to be accorded respect in accordance with *clause 27*.

*Clause 87* entitles every care recipient to appropriate medical treatment and other health care.

*Clause 88* provides that a video or audio tape featuring a care recipient may not be used without the care recipient's consent.

*Clause 89* gives every care recipient the right to seek a second opinion from a specialist assessor of the care recipient's choice.

*Clause 90* gives every care recipient the right to seek legal advice.

*Clause 91* gives every care recipient the right to the company of others, subject to the power to isolate care recipients under *clause 96*.

*Clause 92* gives every care recipient the right, at reasonable times, to receive visitors and to make telephone calls (except where that would be detrimental to the interests of the care recipient).

*Clause 93* gives every care recipient the right to receive all items of mail addressed to the care recipient, and to receive them unopened. However, if there are reasonable grounds for believing that the receipt of an item of mail could be detrimental to the interests and care of the care recipient, the care manager may, with the approval of the Co-ordinator, open and check the item. If, on checking the item, it is considered that the item could be detrimental to the interests and care of the care recipient, the care manager may, with the approval of the Co-ordinator, withhold it from the care recipient. But no item may be withheld from an office-holder listed in *subclause (4)*.

*Clause 94* gives every care recipient rights in relation to the dispatch of mail that are similar to those set out in *clause 93*.

*Clause 95* sets out what must be done when mail is withheld under *clause 93* or *clause 94*. Incoming mail must be returned to the sender or given to the responsible district inspector. Mail that the care recipient wanted dispatched must be given to the responsible district inspector. The care recipient must be informed that mail has been withheld, unless that would be detrimental to the interests and care of the care recipient.

#### SUBPART 2—SPECIFIC POWERS EXERCISABLE OVER CARE RECIPIENTS

*Clause 96* sets out when a care recipient may be isolated from other residents in a facility. This may be done only to the extent that it is necessary to prevent the care recipient from endangering the health or safety of the care recipient or of others, or from seriously compromising the care and well-being of other persons. The room in which a care recipient is isolated must be specifically designed for the purpose in accordance with guidelines issued under the Bill. In any event, the room must provide a safe environment during the care recipient's isolation. The duration and circumstances of each episode must be recorded in a register kept in accordance with guidelines issued under the Bill.

*Clause 97* sets out when a care recipient may be restrained. This may be done only to the extent that it is necessary to prevent the care recipient from endangering the health or safety of the care recipient or of others, or from



seriously damaging property, or from seriously compromising the care and well-being of the care recipient or of other care recipients. A care recipient may not be restrained by a mechanical restraint if it is reasonably practicable for authorised individuals to personally restrain the care recipient. The exercise of restraint may not involve greater force, and may not be applied for longer, than is necessary to achieve the purpose for which the care recipient is restrained. All relevant guidelines issued under the Bill must be complied with when a care recipient is restrained.

*Clause 98* sets out when a care recipient may be given medical treatment without the care recipient's consent. There are 2 bases for administering medical treatment regardless of the care recipient's consent. First, in an emergency, a care recipient may be treated if the treatment is immediately necessary to save the care recipient's life, or to prevent serious damage to the health of the care recipient, or to prevent the care recipient from causing serious injury to the care recipient or to others. Secondly, a care recipient may be given medication for the purpose of managing the condition that gives rise to the care recipient's need for compulsory care. But medication can only be prescribed for that purpose if it is supported by a second opinion given by a medical consultant designated by the Director-General of Health.

#### SUBPART 3—REQUIREMENT TO STAY IN DESIGNATED FACILITIES OR PLACES

*Clause 99* provides that every special care recipient under secure care must stay in a secure facility designated by the Co-ordinator, and may not leave the facility without authority given under the Bill.

*Clause 100* provides for directions that may be given to care recipients who are under supervised care. They may be directed to stay in facilities (but not in secure facilities) or in other places designated by the Co-ordinator. A care recipient who is directed to stay in a facility may not leave the facility without authority given under the Bill.

*Clause 101* authorises the care manager of a civil care recipient who is required to stay in a facility to grant the care recipient up to 3 months' leave from the facility. Any leave granted may be extended up to another 3 months. However, no care recipient may be absent under this clause for a continuous period of more than 6 months. A care recipient's leave is subject to any conditions specified by the care manager, and may be cancelled at any stage.

*Clause 102* authorises the Minister of Health to allow certain special care recipients to be on leave from their facilities. Leave under this clause may not be granted to special care recipients who are detained because they are unfit to stand trial, nor to special care recipients who are remanded to a facility pending a hearing, trial, or sentencing. The Minister may grant leave under this clause only if a specialist assessor certifies that the care recipient is fit to be on leave. Leave granted under this clause is subject to any conditions specified by the Minister, and may be cancelled at any stage.

*Clause 103* allows the Director-General of Health to authorise short-term leave of up to 7 days for special care recipients (other than for remand prisoners).

#### SUBPART 4—STATUS OF SPECIAL CARE RECIPIENTS SUBJECT TO SENTENCES

*Clause 104* relates to a care recipient's liability to detention under a sentence, and provides that liability ends when the care recipient is entitled to be released under the Criminal Justice Act 1985 or when the sentence (which term includes an order of detention) comes to an end.

*Clause 105* provides that, in the case of a person who is liable to detention under a sentence, and also liable to detention in a facility, the sentence runs while the person is in the facility or on authorised leave from the facility. If, in the case of an inmate transferred to a facility, the sentence comes to an end before the care recipient's compulsory care order, the care recipient continues to be held for the remaining term of that order, but as a civil care recipient. In the case of a person on whom a sentence and an order of detention in a secure facility were imposed at the same time, the person's order of detention is, at the end of the sentence, converted into a compulsory care order for a term of 6 months.

*Clause 106* provides that when a person ceases to be a care recipient but does not cease to be liable to detention under a sentence, the person must be taken to a prison to serve the remainder of the sentence.

## PART 7

### DURATION OF COMPULSORY CARE

#### SUBPART 1—CONDITION OF EVERY CARE RECIPIENT TO BE REVIEWED

*Clauses 107 to 109* require the condition of every care recipient to be formally reviewed in sufficient time to enable the results of the review to be included in the report to the Family Court under *clause 78*, and then at 6-monthly intervals. The specialist assessors who review a care recipient must examine the care recipient, and consult with other health professionals involved in the care of the care recipient. On concluding a review of the care recipient, the responsible specialist assessor must complete a certificate as to whether the status of the care recipient needs to be continued or needs to be changed. The form of the certificate is prescribed by the Bill, and depends on the category of care recipient. Special forms of certificate are prescribed for special care recipients detained because they are unfit to stand trial or acquitted on account of insanity as the status of those care recipients is governed by the Criminal Justice Act 1985.

*Clauses 110 and 111* deal with the distribution of certificates issued about care recipients. Copies of a certificate about a care recipient must be given or sent to the care recipient's care manager and to the Co-ordinator, and, in the case of a special care recipient, also to the Director-General of Health. Copies must also be given or sent to the care recipient, any guardian of the care recipient, the care recipient's principal caregiver, and to the responsible district inspector.

#### SUBPART 2—CHANGE IN STATUS OF CIVIL CARE RECIPIENTS AND SPECIAL CARE RECIPIENTS LIABLE TO DETENTION UNDER A SENTENCE

*Clause 112* prescribes the standard form of certificate for care recipients. The specialist assessor must state whether in his or her opinion the care recipient still needs to be cared for as a care recipient; or whether the care recipient no longer needs to be cared for as a care recipient. This form of certificate applies to all care recipients other than special care recipients detained because they are unfit to stand trial or acquitted on account of insanity.

*Clause 113* provides that when a compulsory care order expires, the person affected by the order ceases to be a care recipient.

*Clause 114* allows the Family Court to cancel at any time the compulsory care order of a care recipient if the Family Court is satisfied that the care recipient no longer needs to be cared for as a care recipient. The Family Court can also cancel, on the same ground, an order of detention imposed together with a sentence of imprisonment. The Co-ordinator may apply for a cancellation order at any time, and must apply if a certificate on a review states that the care recipient no longer requires compulsory care.

*Clauses 115 and 116* relate to the extension of a care recipient's compulsory care order. An order may be extended by the Family Court. If a care recipient's order is due to expire when an application for an extension is pending, the Court may defer the expiry of the order so that the care recipient can be detained while the application is heard.

*Clause 117* requires the Co-ordinator and the Family Court to have regard to the certificate following the most recent review of a care recipient when filing or determining applications for the cancellation or the extension of the care recipient's court order.

#### SUBPART 3—STATUS OF CERTAIN SPECIAL CARE RECIPIENTS

*Clauses 118 to 120* deal with the certificates required after the review of special care recipients who are detained because they have been found unfit to stand trial. The specialist assessor who conducted the review must indicate in the certificate whether the special care recipient is still unfit to stand trial; and, if that is the case, whether it is still necessary for the person to be detained as a special care recipient in the person's own interests or in the interests of the safety of any person, class of person, or the public. If a certificate states that a care recipient is no longer unfit to stand trial, the Attorney-General must be notified. If a certificate states that it is no longer necessary for a person to be detained as a special care recipient, the Minister of Health must be notified. This is so that those Ministers can consider the appropriateness of directions under the Criminal Justice Act 1985. Directions that can be given under that Act include a direction that a care recipient who is no longer unfit to stand trial be brought before an appropriate court or that the status of a person change from special care recipient to that of civil care recipient.

*Clauses 121 and 122* deal with the certificates required after the review of special care recipients who are detained because they have been acquitted on account of insanity. The specialist assessor who conducts the review of that class of person must indicate in the certificate whether the continued detention of the person is still necessary in the person's own interests or in the interests of the safety of any person, class of person, or the public. If the certificate states that continued detention as a special care recipient is no longer necessary, the certificate must be forwarded to the Minister of Health. This is so that the Minister of Health can consider the appropriateness of directing, under the Criminal Justice Act 1985, that the person be discharged or held as a civil care recipient.

*Clause 123* provides that when the Attorney-General or the Minister of Justice directs, under the Criminal Justice Act 1985, that the status of a care recipient is to change from special care recipient to civil care recipient, the care recipient is to be regarded as subject to a compulsory care order of a term of 6 months. As soon as practicable after the direction under the Criminal Justice Act 1985, the care recipient must be formally reviewed. If the review indicates that the care recipient is no longer in need of compulsory care, the care recipient must be released.

### PART 8

#### INSPECTIONS AND INQUIRIES

##### SUBPART 1—INSPECTIONS, INVESTIGATIONS, AND INQUIRIES BY DISTRICT INSPECTORS

*Clause 124* requires district inspectors to visit each facility at least 4 times a year at regular intervals. A district inspector does not have to give prior notice of a visit, and may call on a facility at any time. If a specialist assessor is appointed by the Co-ordinator to advise an inspector, the specialist assessor can exercise the powers of an inspector.

*Clause 125* gives an inspector access to every care recipient in a facility, as well as to all relevant documents held in the facility.

*Clause 126* entitles every care recipient to complain to the responsible district inspector about a breach of the care recipient's rights under the Bill. Care managers or Co-ordinators who receive complaints must refer them to the responsible district inspector. If the responsible district inspector receives a complaint that concerns a breach of a right under the Code of Health and Disability Services Consumers' Rights, the Health and Disability Commissioner must be notified of the complaint.

*Clauses 127 to 129* relate to the conduct of investigations. A district inspector must investigate every complaint that does not involve a breach of a right under the Code of Health and Disability Services Consumers' Rights. If an investigation reveals that a complaint has substance, the investigating district inspector must decide whether a formal inquiry under *clause 130* is necessary, or whether the matter can be dealt with by a report, together with any recommendations to the care manager. The care manager concerned must take all steps necessary to correct every deficiency identified in the report. The care recipient must be informed of the outcome of the investigation. If the care recipient (or the person who complained on the care recipient's behalf) is dissatisfied with the outcome, he or she may ask the Director-General of Health to examine the complaint.

*Clause 130* authorises district inspectors to hold formal inquiries into alleged breaches of the Bill and into other breaches of duty on the part of a director, employee, or agent of a service. The Director-General of Health may direct a district inspector to hold an inquiry. In conducting an inquiry, a district inspector can summon witnesses and receive evidence in the same way as a commission of inquiry.

*Clauses 131 to 137* authorise a High Court Judge to inquire into the lawfulness of the detention of a care recipient. The Judge may call for reports or have the care recipient brought to court. In the case of a civil care recipient, the Judge may order the release of the care recipient if satisfied that the care recipient no longer needs to be cared for as a care recipient or that the detention of the care recipient is illegal. In the case of a special care recipient found unfit to stand trial, the Judge can order either that the care recipient stand trial on the charge against the care recipient or that the charge against the care recipient be dismissed. If the Judge is satisfied that it is no longer necessary that a care recipient found unfit to stand trial or acquitted on account of insanity continue to be cared for as a special care recipient, the Judge can order that the care recipient be held as a civil care recipient or order the release of the care recipient. To make such an order, the Judge must be satisfied that neither the care recipient's own interests nor those of the safety of any person, class of person, or the public require the continued care of the care recipient as a special care recipient.

## PART 9

### AUTHORITY TO TAKE AND DETAIN PERSONS

*Clauses 138 and 139* authorise a member of the police to take a person who acts, in a public place, in a manner that gives rise to a reasonable belief that the person has an intellectual disability and is in need of compulsory care, to be examined by a medical practitioner or a psychologist. If the medical practitioner or the psychologist believes on reasonable grounds that the person has an intellectual disability and is in need of compulsory care, the member of the police may take the person for an assessment examination by a specialist assessor. The detention for the purposes of an examination by a medical practitioner or

psychologist, and the detention for the purposes of an assessment examination, are each restricted to a maximum of 6 hours (or less if the examination or the assessment takes less time).

*Clauses 140 and 141* authorise persons in charge of facilities to admit persons who are required to stay in the facility under a court order, and to take all reasonable steps to detain those persons in the facility while the order is in force.

*Clause 142* defines the expression “care recipient who has escaped”.

*Clause 143* authorises care recipients who have escaped to be retaken and returned.

*Clause 144* enables warrants to be issued authorising members of the police to enter places to retake care recipients who have escaped.

*Clause 145* authorises a member of the police to enter a place without a warrant to retake a care recipient who has escaped and who is endangering his or her health or safety or the health or safety of others.

*Clauses 146* enables warrants to be issued authorising members of the police to take care recipients who are not complying with court orders to the facilities that they are required to attend or stay at.

*Clause 147* sets out safeguards that members of the police must observe when they enter places under *clauses 144, 145, or 146*.

*Clause 148* protects persons who exercise coercive powers in reliance on the provisions of the Bill, or on orders or warrants made or issued under it, from criminal responsibility.

## PART 11

### PROCEDURAL PROVISIONS

*Clause 149* requires every application under the Bill to be heard in a Family Court. However, if an application has to be determined within a particular period, and it is not practicable to have the application determined in that period by a Family Court Judge, any District Court Judge may hear the application.

*Clauses 150 to 153* specify the persons who may appear on applications and be served with copies of the relevant documents.

*Clause 154* requires the responsible district inspector to consider whether to appear and be heard at the hearing of each application. The district inspector must talk to the care recipient, and find out what the care recipient thinks about the matter.

*Clause 155* provides that the care recipient must be present throughout the hearing of every application unless the Judge who has examined the care recipient has certified that it would be in the best interests of the person to excuse the person from attending the hearing, or the care recipient is excused or excluded by the Court under *clause 156*. The care recipient may be supported at the hearing of an application by a person chosen by the proposed care recipient or chosen by the care recipient’s guardian, or principal caregiver, or friend, but the support person is not entitled to be heard at the hearing.

*Clause 156* authorises the Court to excuse the care recipient from the hearing of the application if the care recipient wholly lacks the capacity to understand the nature and purpose of the application, or that attendance or continued attendance is likely to cause the person serious mental, emotional, or physical

harm, or that the care recipient is causing a disturbance that makes it impracticable to continue with the hearing in his or her presence.

*Clause 157* provides that every person who is entitled to appear and be heard at a hearing of an application may be represented by a lawyer, and may call witnesses, and may cross-examine every witness called by another party to the proceeding. If the care recipient is present and appears capable of addressing the Court, the care recipient is permitted to do so. While the care recipient is addressing the Court, the Court may exclude a parent or guardian of the care recipient, or anybody else with whom the care recipient is living, or a lawyer representing persons of that description.

*Clause 158* authorises the Court to appoint a lawyer to represent the care recipient.

*Clause 159* authorises the Court to request an expert to prepare a report on the care recipient. A lawyer representing a party to the proceeding may be given a copy of such a report and ordered not to show it to the party if the Court believes that disclosure of the contents of the report may pose a serious threat to the care recipient or to any other person.

*Clause 160* allows evidence to be given on the issues dealt with in a report under *clause 159*. The expert who prepared the report may be called as a witness.

*Clause 161* provides that, in proceedings under the Bill, the Court is not bound by the rules of evidence.

*Clause 162* authorises the Court to call witnesses to give evidence in proceedings under the Bill.

*Clause 163* provides that proceedings under the Bill are not open to the public.

*Clause 164* makes it an offence to publish a report of proceedings under the Bill except with the leave of the court that heard the proceedings.

*Clause 165* authorises the Court to determine an application without a formal hearing if no person wishes to be heard on the application.

*Clause 166* requires the Registrar, after an order is made on an application under the Bill, to give the care recipient and the care recipient's lawyer and guardian a copy of the order.

*Clause 167* gives parties to proceedings under the Bill a right of appeal to the High Court.

*Clause 168* provides for a further appeal to the Court of Appeal. Such an appeal requires the leave of the Court of Appeal, and is limited to a question of law.

*Clause 169* provides that an appeal does not affect the operation of the order appealed against.

## PART 11

### RELATIONSHIP WITH OTHER ACTS

*Clause 170* provides for the application of the Bill to mentally disordered persons. Compulsory care orders under the Bill may not be made for patients or proposed patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992. When a care recipient is assessed under the Mental Health (Compulsory Assessment and Treatment) Act 1992, any compulsory care order that the care recipient is subject to is suspended. The suspended order is revived

when the care recipient is released from compulsory status under the Mental Health (Compulsory Assessment and Treatment) Act 1992. A special care recipient who is transferred to the regime under the Mental Health (Compulsory Assessment and Treatment) Act 1992 must be held as a special patient under that Act.

*Clause 171* provides that the Bill prevails over the Protection of Personal and Property Rights Act 1988.

*Clause 172* provides that the provisions of the Bill can apply to a child or young person, even if the child or young person is subject to an order under the Children, Young Persons, and Their Families Act 1989. Conversely, the fact that a child or young person is subject to a compulsory care order under the Bill does not stop the making of an order under the Children, Young Persons, and Their Families Act 1989 in respect of the child or young person. If there is an inconsistency between Part II of the Children, Young Persons, and Their Families Act 1989 (which relates to the care and protection of children and young persons) and the Bill, the Bill prevails.

*Clause 173* provides that when a care recipient is, in the course of a criminal proceeding, remanded to a hospital or secure facility for an assessment or is detained in a hospital or secure facility pending the person's trial, any order made under the Bill in respect of the person is suspended. A care recipient's compulsory care order ceases to have effect if the care recipient is ordered, in the course of a criminal proceeding, to be detained as a special care recipient under the Bill or as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992. A care recipient's compulsory care order also ceases to have effect if the care recipient is sentenced to imprisonment.

## PART 12 ADMINISTRATION

*Clause 174* provides for the appointment of Compulsory Care Co-ordinators ("Co-ordinators").

*Clause 175* requires the Co-ordinator to designate a care manager for each care recipient. A care manager must be an individual who is an employee or agent of an organisation that provides services for persons who have an intellectual disability.

*Clauses 176 and 177* authorise Co-ordinators and care managers to delegate any of their powers, duties, and functions, except the power of delegation, to a person who is suitably qualified to exercise them.

*Clause 178* provides for the remuneration of district inspectors, who are appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992, for work done under the Bill.

*Clause 179* protects district inspectors from civil proceedings for any thing done or reported or said in the course of the exercise or intended exercise of their powers under the Bill.

*Clause 180* provides for the designation of health or disability professionals who are experts on intellectual disability as specialist assessors for the purposes of this Act; and also for the designation of medical practitioners as medical consultants who are authorised to give second opinions on proposals to medicate care recipients for the purpose of managing the care recipients' condition.

*Clause 181* authorises the Director-General of Health to issue guidelines for the purposes of the Bill, and standards of care and treatment of care recipients.

*Clause 182* authorises the Governor-General, by Order in Council, to make rules regulating the practice and procedures of Family Courts in proceedings under the Bill.

*Clause 183* authorises the Governor-General, by Order in Council, to make regulations. The purposes for which regulations may be made include prescribing the powers and duties of district inspectors, and regulating the management of secure care facilities.

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**INTELLECTUAL DISABILITY (COMPULSORY CARE)**

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## A BILL INTITULED

**An Act to provide for the compulsory care of persons who have an intellectual disability and are in need of compulsory care**

BE IT ENACTED by the Parliament of New Zealand as follows: 5

**1. Short Title and commencement—**(1) This Act may be cited as the Intellectual Disability (Compulsory Care) Act 1999.

(2) This Act comes into force on a date to be appointed by the Governor-General by Order in Council; and 1 or more

Orders in Council may be made appointing different dates for different provisions.

PART 1

OUTLINE OF THIS ACT

- 5     **2. Purpose of this Part**—This Part is intended—  
    (a) To give a general indication of what this Act is about:  
    (b) To indicate how this Act is arranged:  
    (c) To assist readers to identify the provisions that are relevant to them.
- 10    **3. Status of this Part**—This Part is intended as a guide to the general scheme and effect of this Act.
- 4. What this Act is about**—(1) This Act provides for a regime of compulsory care for individuals who have an intellectual disability and require compulsory care in accordance with a court order.  
    (2) The Act provides for assessment processes to ensure that the powers under the Act are used appropriately.  
    (3) The Act gives persons in need of compulsory care certain rights, and sets out safeguards against abuse.
- 20    **5. How this Act is arranged**—This Act is arranged in Parts, as follows:  
    Part 1—Outline of this Act:  
    Part 2—Preliminary Provisions:  
    Part 3—Objects, Principles, and General Duties:  
25    Part 4—Assessments:  
    Part 5—Compulsory Care Orders:  
    Part 6—Status and Rights of Care recipients:  
    Part 7—Duration of Compulsory Care:  
    Part 8—Inspections and Inquiries:  
30    Part 9—Authority to Take and Detain Persons:  
    Part 10—Procedural Provisions:  
    Part 11—Relationship with Other Acts:  
    Part 12—Administration.
- 35    **6. Part 2 (Preliminary provisions)**—Part 2 sets out the key terms that are essential to an understanding of this Act, and what various terms used in the Act mean. It deals with matters like—
- What does “in need of compulsory care” or “intellectual disability” mean?

- Who is a “care recipient” or a “Co-ordinator”?

**7. Part 3 (Objects, principles, and general duties)**—Part 3 sets out the objects of this Act and the principles and duties of general application that persons exercising powers under the Act must observe. It deals with matters like—

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- What approach should be taken to making compulsory care orders?
- How should persons covered by this Act be treated?
- What principles govern decisions affecting children and adolescents under 17 years?

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**8. Part 4 (Assessments)**—Part 4 sets out how persons can be required to undergo assessments to establish if they have an intellectual disability and are in need of compulsory care; and, if that is the case, what kind of care they should receive. It deals with matters like—

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- When can a person be assessed?
- Once an assessment has been made that a person has an intellectual disability and is in need of compulsory care, how are his or her care needs assessed?
- What matters have to be set out in a care plan?

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**9. Part 5 (Compulsory care orders)**—Part 5 sets out the matters that compulsory care orders and care plans have to address. It deals with matters like—

- When can the Family Court make a compulsory care order?
- What is the maximum term of a compulsory care order?
- When is a compulsory care order reviewed by the Family Court, and what are the powers of the Court on review?

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**10. Part 6 (Status and rights of care recipients)**—Part 6 sets out what being a person covered by this Act, either as civil care recipient or as a special care recipient, involves. It deals with matters like—

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- What limits are imposed on the freedom of care recipients?
- What special rights do care recipients have?
- Where are care recipients required to stay?

- 5     **11. Part 7 (Duration of compulsory care)**—Part 7 sets out how the status of a person as a civil care recipient or as a special care recipient is terminated. It deals with matters like—
- How often does the condition of a care recipient have to be reviewed by a specialist assessor?
  - In what circumstances can a civil care recipient be detained after his or her compulsory care order has expired?
  - In what circumstances can a civil care recipient be released before his or her compulsory care order has expired?
- 10    **12. Part 8 (Inspections and inquiries)**—Part 8 sets out provisions for inspections, investigations, and inquiries, including inquiries by High Court Judges, into whether persons are lawfully detained under this Act. It deals with matters like—
- 15    • How do inspectors protect the rights and interests of care recipients?
- What action must be taken when a care recipient complains about a breach of the care recipient’s rights?
- 20    **13. Part 9 (Authority to take and detain persons)**—Part 9 sets out the circumstances when persons may be taken and detained. It deals with matters like—
- 25    • When, and for what purpose, may a member of the police detain a person who appears to have an intellectual disability and be in need of compulsory care?
- Who may retake a care recipient who is absent from the care recipient’s designated facility without authority?
- 30    **14. Part 10 (Procedural provisions)**—Part 10 sets out how applications to the Family Court are heard and determined. It deals with matters like—
- Who is entitled to be heard at a hearing of an application?
- In what circumstances can the person who is the subject of the application be excluded from the hearing?
- Are hearings open to the public?
- 35    **15. Part 11 (Relationship with other Acts)**—Part 11 sets out when the Act does or does not apply. It deals with matters like—
- Does this Act apply to persons who are mentally disordered?

- What is the relationship between this Act and the Children, Young Persons, and Their Families Act 1989?

**16. Part 12 (Administration)**—Part 12 sets out how persons who perform functions under this Act are appointed. It also authorises the making of guidelines, rules, and regulations for the purposes of the Act. It deals with matters like— 5

- How are co-ordinators appointed?
- Who may make guidelines for the purposes of this Act?

## PART 2

### PRELIMINARY PROVISIONS 10

#### SUBPART 1—DEFINITIONS AND KEY TERMS

**17. Interpretation**—In this Act, unless the context otherwise requires,—

“Care manager”, means a person designated under section 175: 15

“Care plan”, in relation to a care recipient, means the care plan prepared for the care recipient, under section 54, as varied from time to time under this Act:

“Care programme” means a programme that— 20  
 (a) Is included in a care recipient’s care plan; and  
 (b) Provides for the matters specified in section 56:

“Care recipient” has the meaning given to it by section 18:

“Child” has the same meaning as in section 2 (1) of the Children, Young Persons, and Their Families Act 1989: 25

“Civil care recipient” has the meaning given to it by section 18 (2):

“Code of Rights” means the Code of Health and Disability Services Consumers’ Rights for the time being in force under the Health and Disability Commissioner Act 1994: 30

“Compulsory care order” means an order made under section 73 or an order made under section 115B (1) (b) or section 118 (1) (b) (iii) <sup>1</sup> of the Criminal Justice Act 1985; and includes the order as varied from time to time: 35

“Co-ordinator” means a Compulsory Care Co-ordinator appointed under section 174; and, in relation to a function, duty, or power, means the person appointed under that section who is responsible for

<sup>1</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)



the geographical area in which the function is to be performed, or the duty or power is to be exercised:

5 “Court order” means a compulsory care order or an order under section 115A (2) (b) or section 118 (1) (a) (iii)<sup>2</sup> of the Criminal Justice Act 1985; and includes the order as varied from time to time:

“Director-General” has the same meaning as in section 2 (1) of the Health Act 1956:

10 “District inspector”, means a person appointed as a district inspector or deputy district inspector under the Mental Health (Compulsory Assessment and Treatment) Act 1992:

“Facility” has the meaning given to it by section 22:

15 “Friend”, in relation to a care recipient, means a person who has been nominated by the care recipient for the purposes of—

(a) Helping the care recipient express his or her wishes or needs; and

20 (b) Trying to explain to the care recipient the recommendations and requirements of persons exercising authority over the care recipient:

“Guardian” includes a welfare guardian:

“In need of compulsory care” has the meaning given to it by section 19:

25 “Inmate” means a person who is liable to be detained in a prison—

(a) Under a sentence; or

30 (b) While awaiting or during the course of a hearing or trial before a court or while awaiting sentence by a court or pending the determination of an appeal to a court:

“Intellectual disability” has the meaning given to it by section 20:

35 “Interim order” means an interim order made under section 58:

“Lawyer” means a barrister or solicitor, as those terms are defined in section 2 of the Law Practitioners Act 1982:

40 “Medical practitioner” means a medical practitioner registered under the Medical Practitioners Act 1995:

<sup>2</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

- “Mental disorder” has the same meaning as in the Mental Health (Compulsory Assessment and Treatment) Act 1992:
- “Minister” means the Minister of Health:
- “Principal caregiver”, in relation to a care recipient, means 5  
the person who is most evidently and directly  
concerned with the oversight of the care recipient’s  
care and welfare:
- “Prison” means a penal institution within the meaning of 10  
the Penal Institutions Act 1954:
- “Proposed care recipient” has the meaning given to it by  
section 18 (4):
- “Psychologist” means a psychologist registered under the  
Psychologists Act 1981:
- “Responsible district inspector”, in relation to a care 15  
recipient, means the district inspector who is  
appointed, under the Mental Health (Compulsory  
Assessment and Treatment) Act 1992, in respect of  
the location in which the care recipient is staying:
- “Secure care” means care given to a care recipient who is 20  
required to stay in a secure facility:
- “Secure facility” has the meaning given to it by section 22 (2):
- “Sentence” includes an order of committal or an order of  
detention:
- “Service” means an organisation that provides services for 25  
persons who have an intellectual disability (whether  
or not it also provides services for persons who do not  
have an intellectual disability):
- “Special care recipient” has the meaning given to it by  
section 18 (3): 30
- “Specialist assessor” or “assessor” means an appropriately  
qualified health or disability professional who is for  
the time being designated by the Director-General for  
the purposes of this Act:
- “Supervised care” means care given to a care recipient 35  
who may be directed to stay in a facility or in another  
place:
- “Welfare guardian” has the same meaning as in section 2  
of the Protection of Personal and Property Rights Act  
1988: 40
- “Without notice”, in relation to an application, has the  
same meaning as *ex parte*:
- “Young person” has the same meaning as in section 2 (1)  
of the Children, Young Persons, and Their Families  
Act 1989. 45

**18. Meaning of “care recipient” and related terms—**

- (1) A care recipient is—
- (a) A civil care recipient; or
  - (b) A special care recipient; or
  - 5 (c) A proposed care recipient.
- (2) A civil care recipient is a person—
- (a) Who is subject to a compulsory care order; but
  - (b) Who is not a special care recipient.
- (3) A special care recipient is a person who is required to be
- 10 detained in a facility because—
- (a) The person has been found unfit to stand trial or has been acquitted on account of his or her insanity and, following that finding or acquittal, a court—
    - 15 (i) Has remanded the person, under section 115<sup>3</sup> of the Criminal Justice Act 1985, to a facility to determine the most suitable method of dealing with the person; or
    - (ii) Has ordered, under section 115A<sup>4</sup> of the Criminal Justice Act 1985, that the person be detained as a special care recipient; or
  - 20 (b) The person has been charged with an offence, and a court has ordered, under section 121 (2)(c)<sup>5</sup> of the Criminal Justice Act 1985, that the person be detained in a facility for the purpose of assessing the person; or
  - 25 (c) The person has been charged with, or convicted of, an offence, and a court has ordered, under section 121E (1)<sup>6</sup> of the Criminal Justice Act 1985 or section 171 (3A)<sup>7</sup> of the Summary Proceedings Act 1957, that the person
  - 30 be detained in a facility pending the hearing or trial, or the sentencing, for the offence; or
  - (d) The person—
    - (i) Is liable to detention under a sentence that was passed together with an order under

<sup>3</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

<sup>4</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

<sup>5</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

<sup>6</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

<sup>7</sup> As proposed to be inserted by clause 20 of the Criminal Justice Amendment Bill (No. 7)

- section 118 (1) (a) (ii) <sup>8</sup> of the Criminal Justice Act 1985;  
and
- (ii) Has not ceased, under section 105, to be a special care recipient; or
- (e) The person is liable to detention under a sentence and— 5
- (i) Is required to be detained in a facility following an application under section 63; and
  - (ii) Has not ceased, under section 105, to be a special care recipient.
- (4) A proposed care recipient is a person— 10
- (a) Who is being assessed under Subpart 1 or Subpart 2 of Part 4; or
  - (b) In respect of whom an application for a compulsory care order is pending before the Family Court.
- (5) In this Act, the expression “care recipient liable to detention under a sentence” refers to a special care recipient to whom subsection (3) (d) or subsection (3) (e) applies. 15

**19. Meaning of “in need of compulsory care”**—A person is in need of compulsory care if the person exhibits behaviour—

- (a) That poses a serious danger to the health or safety of that person or of others; and 20
- (b) That cannot be effectively managed without relying on this Act.

**20. Meaning of “intellectual disability”**—(1) A person has an intellectual disability if the person has a permanent impairment that— 25

- (a) Results in significantly sub-average general intelligence as measured by standard psychometric tests generally used by clinicians; and
  - (b) Results in significant deficits, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (3); and 30
  - (c) Became apparent during the developmental period of the person.
- (2) For the purposes of subsection (1) (a), an intelligence quotient of 70 or less is indicative of significantly sub-average general intelligence. 35
- (3) The skills referred to in subsection (1) (b) are—
- (a) Communication:
  - (b) Self-care: 40
  - (c) Home living:

<sup>8</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

- (d) Social skills:
- (e) Use of community services:
- (f) Self-direction:
- (g) Health and safety:
- 5 (h) Reading, writing, and arithmetic:
- (i) Leisure and work.
- (4) For the purposes of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.
- 10 (5) This section is subject to section 21.

**21. Persons who do not have intellectual disability**—A person does not have an intellectual disability simply because the person—

- (a) Has a mental disorder; or
- 15 (b) Does not feel shame or remorse about harm the person causes to others.

**22. Meaning of “facility” and “secure facility”**—(1) A facility is a place that is used by a service for the purpose of providing care to persons who have an intellectual disability  
20 (whether or not the place is also used for other purposes).

- (2) A secure facility is a facility that—
  - (a) Has particular features that are designed to prevent persons required to stay in the facility from leaving the facility without authority; and
  - 25 (b) Is operated in accordance with systems that are designed to achieve that purpose.
- (3) A prison is not a facility.

SUBPART 2—APPLICATION TO CROWN

**23. Crown bound**—This Act binds the Crown.

30

PART 3

OBJECTS, PRINCIPLES, AND GENERAL DUTIES

**24. Objects**—The objects of this Act are—

- (a) To protect individuals subject to this Act and others from any serious harm that those individuals may do to the health or safety of those individuals or of others; and
- 35 (b) To recognise and safeguard the special rights of individuals subject to this Act; and
- (c) To provide for the appropriate use of different levels of care for individuals subject to this Act.

**25. Principles governing exercise of powers under this Act**—(1) Whenever a court or a person exercises, or proposes to exercise, a power under this Act, the court or person must be guided by the principles specified in this section that are relevant to the exercise or proposed exercise of the power. 5

(2) A compulsory care order is an intervention of last resort that should be made only if other support or care arrangements are insufficient to prevent the person for whom the order is proposed from posing a serious danger to the health or safety of that person or of others. 10

(3) Every care recipient should receive care that protects—

(a) The health and safety of the care recipient and of others; and

(b) The rights of the care recipient.

(4) Subsection (2) does not apply to a compulsory care order that is made in respect of an inmate. 15

**26. Principles governing decisions affecting children and young persons**—(1) Whenever a court or a person exercises, or proposes to exercise, a power conferred by or under this Act over a child or young person, the court or person must be guided by any of the following principles that are relevant to the exercise or proposed exercise of the power: 20

(a) The welfare and interests of the child or young person must be the first and paramount consideration:

(b) The child or young person should not become subject to a compulsory care order unless the child or young person requires long-term compulsory care: 25

(c) Wherever possible, the family, whanau, hapu, iwi, and family group of the child or young person should participate in the making of decisions affecting the child or young person, and, accordingly, regard should be had to the views of the family, whanau, hapu, iwi, and family group: 30

(d) Wherever possible, the links of the child or young person with his or her family, whanau, hapu, iwi, and family group should be maintained and strengthened: 35

(e) A decision affecting the child or young person may be taken only after consideration of the likely impact of the decision—

(i) On the welfare of the child or young person; and 40

(ii) On the stability of the family, whanau, and family group of the child or young person:

(f) Consideration should be given to the wishes of the child or young person, to the extent that those wishes can

reasonably be ascertained, and those wishes should be given the weight that is appropriate in the circumstances, having regard to the age, maturity, and culture of the child or young person:

5 (g) The exercise of a power under this Act in relation to the child or young person should proceed only if endeavours have been made to obtain the support to the proposed exercise of the power from the following persons:

10 (i) The parents or guardians or principal caregivers of the child or young person:

(ii) The child or young person:

15 (h) Decisions affecting the child or young person should, whenever practicable, be made and implemented within a time-frame that is appropriate to the sense of time of the child or young person.

20 (2) The principle that a compulsory care order is a measure of last resort set out in section 25 (2) prevails over each principle set out in subsection (1) to the extent that there is an inconsistency between the principles.

**27. Powers to be exercised with proper respect for cultural identity and personal beliefs—**(1) This section applies to—

25 (a) A court or person exercising a power under this Act in respect of a care recipient; and

(b) A court conducting proceedings under this Act in respect of a care recipient.

(2) The power must be exercised, or the proceedings conducted,—

30 (a) With proper recognition of the importance and significance to the care recipient of the care recipient's ties with his or her family, whanau, hapu, iwi, and family group; and

35 (b) With proper recognition of the importance and significance to the care recipient's family, whanau, hapu, iwi, and family group of the ties of the family, whanau, hapu, iwi, and family group with the care recipient; and

40 (c) With proper recognition of the contribution the ties specified in paragraphs (a) and (b) make to the care recipient's well-being; and

(d) With proper respect for the care recipient's cultural and ethnic identity, language, and religious or ethical beliefs; and

- (e) With proper respect for the competencies and autonomy of the care recipient by keeping all procedures, so far as this can be done, within the care recipient's power of understanding.

Cf. 1992, No. 46, s. 5

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**28. Interpreters to be provided**—(1) This section applies to—

- (a) A court or person exercising a power under this Act in respect of a care recipient; and
- (b) A court conducting proceedings under this Act in respect of a care recipient; and 10
- (c) A person discharging a duty under this Act—
- (i) To provide information or advice to a care recipient; or
- (ii) To ascertain the wishes of the care recipient. 15
- (2) The court or person must ensure that the services of an interpreter are provided for the care recipient if—
- (a) One of the following applies:
- (i) The first or preferred language of the care recipient is Maori or another language other than English; or 20
- (ii) The care recipient is unable, because of physical or intellectual disability, to understand English; or
- (iii) The care recipient is able to understand the substance of the matter in issue, but only if it is interpreted by an interpreter; and 25
- (b) It is practicable to provide the services of an interpreter.
- (3) In selecting or approving an interpreter for the purposes of this section, the court or person must have regard to any views that the care recipient concerned has on the matter. 30

Cf. 1992, No. 46, s. 6

#### PART 4

##### ASSESSMENTS

SUBPART 1—ASSESSMENT TO ASCERTAIN IF PROPOSED CARE RECIPIENT HAS AN INTELLECTUAL DISABILITY AND IS IN NEED OF COMPULSORY CARE 35

**29. Application for assessment**—(1) A person (in this Subpart referred to as the applicant) who believes that another person has an intellectual disability and is in need of compulsory care may apply to the Co-ordinator to have that other person assessed under this Subpart. 40

- (2) The applicant must be 18 years or over.



(3) The applicant may be the person who gives the certificate in support of the application under section 31.

Cf. 1992, No. 46, s. 8 (1), (4)

5     **30. Matters to be stated in application**—(1) An application under section 29 must be in writing, and must set out—

- (a) The applicant's reasons for believing that the person to be assessed has an intellectual disability and is in need of compulsory care; and
- 10    (b) The applicant's relationship or association with the person to be assessed.

(2) Every application must also state that the applicant has personally seen the person to be assessed within the 3 days immediately before the date of the application.

15     Cf. 1992, No. 46, s. 8 (2),

**31. Application to be accompanied by certificate**—(1) Every application under section 29 must be supported by a certificate of a person who—

- (a) Is a medical practitioner or a psychologist; and
- 20    (b) If another person is the applicant, is not related to the applicant; and
- (c) Is not related to the person to be assessed; and
- (d) Has examined the person to be assessed within the 3 days immediately before the date of the application.
- 25    (2) Every certificate given under subsection (1) must state—
- (a) That the person giving the certificate is a medical practitioner or a psychologist and has examined the person to be assessed, and the date of the examination; and
- 30    (b) If another person is the applicant, that the person giving the certificate is not related to the applicant; and
- (c) That the person giving the certificate is not related to the person to be assessed; and
- 35    (d) That, in the opinion of the person giving the certificate, there are reasonable grounds for believing that the person to be assessed may have an intellectual disability and be in need of compulsory care; and
- 40    (e) The reasons for that opinion, explaining why the person giving the certificate believes that the condition of the person to be assessed may come within the definition of the term "intellectual disability" in section 20, and

also within the definition of the term “in need of compulsory care” in section 19.

Cf. 1992, No. 46, s. 8 (3)

**32. Co-ordinator to initiate assessment**—(1) If the Co-ordinator considers that an application under section 29 is properly made, the Co-ordinator must initiate the assessment sought by the applicant. 5

(2) However, the Co-ordinator may not initiate an assessment if the person to be assessed has recently been assessed, and there is no reason for believing that the circumstances of the person have changed. 10

(3) If a person has been examined by a medical practitioner or psychologist who has stated the matters specified in section 31 (2) about the person, then (even though no application has been made under section 29) the Co-ordinator may initiate the assessment of the person if there are reasonable grounds for believing— 15

(a) That the person may have an intellectual disability and be in need of compulsory care; and

(b) That it is necessary for the person to be assessed as a matter of urgency either in the interests of the public or in the interests of the person. 20

**33. Arrangements for assessment**—(1) The Co-ordinator initiates an assessment of a proposed care recipient—

(a) By designating a care manager for the proposed care recipient in accordance with section 175; and 25

(b) By making the necessary arrangements.

(2) The arrangements referred to in subsection (1) include—

(a) Designating 1 or more specialist assessors who are to conduct the assessment; and 30

(b) Fixing, in consultation with that person or those persons, the time and place for an assessment examination.

(3) Even though the Co-ordinator has not received an application for the assessment of a person, he or she may initiate the assessment if notice of the application is received, whether by telephone or otherwise, from a medical practitioner or psychologist who has given a certificate in respect of that person for the purposes of section 31. 35

(4) When the Co-ordinator initiates an assessment under subsection (3), the assessment examination may not take place until the written application and the accompanying certificate 40

have been received by the Co-ordinator or by a specialist assessor involved in conducting the assessment.

Cf. 1992, No. 46, s. 9 (2), (3)

5     **34. Certifying medical practitioner or psychologist may not conduct assessment**—In no case may the medical practitioner or psychologist who gave the certificate in support of the assessment of a proposed care recipient be a specialist assessor involved in conducting the assessment.

Cf. 1992, No. 46, s. 9 (3)

10    **35. Assessment examination of child or young person**—Whenever practicable, a specialist assessor who practises in the field of child and adolescent disability must be involved in the conduct of an assessment examination of a child or young person.

15     Cf. 1992, No. 46, s. 86

**36. Proposed care recipient requested to attend**—  
(1) After fixing the time and place for the assessment examination of a proposed care recipient, the Co-ordinator must sign a written notice that—

20     (a) Requests the proposed care recipient to attend the assessment examination on a date and at a time and place specified in the notice; and

      (b) Tells the care recipient who will conduct the assessment; and

25     (c) Explains the purpose of the assessment.

      (2) The notice must be in a form that the care recipient is most likely to understand.

      (3) The Co-ordinator must give the notice to the following persons:

30     (a) The proposed care recipient:

      (b) Any welfare guardian of the proposed care recipient:

      (c) If the proposed care recipient is a child or young person, each parent or guardian of the child or young person:

35     (d) If the proposed care recipient is a child or young person who is not residing with any of his or her parents or guardians, any person—

      (i) With whom the care recipient is living; and

40     (ii) Who has had the care of the care recipient for a period of not less than 6 months immediately before the application was made:

      (e) The principal caregiver of the proposed care recipient.

**37. Finding out if care recipient agrees to be assessed—**

(1) When the notice is given to the proposed care recipient, the Co-ordinator must—

(a) Make all reasonable efforts to explain the purpose of the assessment and the requirements of the notice to the proposed care recipient in the presence of any guardian of the proposed care recipient and of the principal caregiver of the proposed care recipient; and 5

(b) Give each of those persons a document that sets out the matters to be explained in a form that the proposed care recipient is most likely to understand. 10

(2) The Co-ordinator must—

(a) Ask the proposed care recipient to consider, within a specified period, whether the proposed care recipient will consent to attend the assessment examination; or 15

(b) If the care recipient is not capable of consenting, ask any guardian of the proposed care recipient to consider, within a specified period, whether to consent on the proposed care recipient's behalf. 20

(3) The period specified under subsection (2) may not be less than 48 hours unless there is an imminent risk that the proposed care recipient will endanger the health or safety of the care recipient or of others.

(4) If the appropriate person consents under subsection (2), the Co-ordinator must assist the proposed care recipient to attend the assessment examination. 25

(5) If the appropriate consent is not given under subsection (2), the Co-ordinator must consider whether an application under Subpart 3 may be desirable. 30

Cf. 1992, No. 46, s. 9 (2)

**38. Assessment examination—**(1) The specialist assessor or assessors designated under section 33 (2) (a) must conduct an assessment examination—

(a) To ascertain whether the proposed care recipient has an intellectual disability and is in need of compulsory care; and 35

(b) If that is the case, to assess the level of care that is required to manage the risk that the care recipient's behaviour poses to the health and safety of the care recipient or of others. 40

(2) Unless consultation is not practicable, the specialist assessor or one of the assessors involved in the assessment

examination must consult with the following persons about the proposed care recipient's condition and background:

- (a) The proposed care recipient's principal caregiver:
- (b) Any welfare guardian of the proposed care recipient:
- 5 (c) If the proposed care recipient is a child or young person, each parent or guardian of the child or young person:
- (d) If the proposed care recipient is a child or young person who is not residing with any of his or her parents or guardians, any person—
  - 10 (i) With whom the care recipient is living; and
  - (ii) Who has had the care of the care recipient for a period of not less than 6 months immediately before the application was made:
- (e) The care recipient's family or whanau.

15 **39. Assessments requiring further sessions**—(1) If, after examining a proposed care recipient, the specialist assessor or assessors involved in the examination consider that it is not possible to ascertain, on the basis of that examination, whether the proposed care recipient has an intellectual disability and is  
20 in need of compulsory care, the assessor or assessors must advise the Co-ordinator—

- (a) Whether the proposed care recipient will need to stay in a facility to enable the proposed care recipient's assessment to be completed; or
- 25 (b) If the proposed care recipient will not need to stay in a facility, about the details of the further examination or examinations the care recipient will need to attend.

(2) In any case where the Co-ordinator is advised that the  
30 proposed care recipient needs to stay in a facility, the Co-ordinator must—

- (a) Ask the proposed care recipient to consider, within a specified period, whether the proposed care recipient will consent to stay in the facility; or
- 35 (b) If the care recipient is not capable of consenting, ask any guardian of the proposed care recipient to consider, within a specified period, whether to consent on the proposed care recipient's behalf.

(3) The period specified under subsection (3) may not be less  
40 than 48 hours unless there is an imminent risk that the proposed care recipient will endanger the health or safety of the care recipient or of others.

(4) If the appropriate consent is not given under subsection (2), the Co-ordinator must consider whether an application under Subpart 3 may be desirable.

**40. Maximum period of assessment—**(1) The assessment, under this Subpart, of a proposed care recipient must be completed as quickly as practicable. 5

(2) In no case may the assessment continue for longer than 30 days after the date on which the proposed care recipient is given the notice under section 36.

**41. Report on whether proposed care recipient in need of compulsory care—**(1) On finishing the assessment of a proposed care recipient, the specialist assessor or assessors designated under section 33 (2) (a) must set out in a report to the Co-ordinator whether the proposed care recipient has been assessed as a person who has an intellectual disability and is in need of compulsory care. 10 15

(2) If more than 1 specialist assessor has been designated under section 33 (2) (a) to assess a proposed care recipient, an assessment of the care recipient is effective only if every designated assessor concurs with the assessment. 20

**42. Where proposed care recipient not assessed to need compulsory care—**(1) If the Co-ordinator receives a report under section 41 that does not indicate that a person has been assessed as a person who has an intellectual disability and is in need of compulsory care, the Co-ordinator must immediately— 25

(a) Advise the person of that result; and

(b) Ensure that the person is released from the requirements imposed on the person under this Act; and

(c) If the person was subject to an interim order under section 58, give the persons specified in section 60 written notice that the order has expired; and 30

(d) Take steps to ensure that the person is provided with reasonable assistance to re-enter the community.

(2) Nothing in this section precludes 1 or more further assessments of a person's condition in accordance with section 32. 35

**43. Where proposed care recipient assessed to be in need of compulsory care—**If the Co-ordinator receives a duly completed report given under section 41 that a proposed care recipient has an intellectual disability and is in need of compulsory care, the Co-ordinator must, without undue delay, 40

initiate a process for assessing the care needs of the proposed care recipient under **Subpart 2**.

SUBPART 2—ASSESSMENT OF CARE NEEDS

5 **44. Purposes of needs assessment**—The purposes of the process for assessing the needs of a proposed care recipient are—

- (a) To assess the kind of care that the proposed care recipient needs; and
- 10 (b) To identify 1 or more suitable services capable of providing care of that kind for the proposed care recipient; and
- (c) To prepare a care plan for the proposed care recipient.

**45. Commencement of needs assessment process**—  
15 (1) The Co-ordinator must commence the needs assessment process by holding a meeting with the proposed care recipient, and any member of the proposed care recipient's family or a caregiver of the proposed care recipient or someone else concerned with the welfare of the proposed care recipient.

(2) At the meeting held under **subsection (1)**, the Co-ordinator must use his or her best endeavours to explain—

- 20 (a) The result of the assessment of the proposed care recipient under **Subpart 1**; and
- (b) The purpose of the needs assessment.

**46. Maximum period of needs assessment process**—  
25 (1) The process for assessing the needs of a proposed care recipient must be completed as quickly as practicable.

(2) The process for assessing the needs of a proposed care recipient may not continue for longer than 30 days after the date on which the process commences in accordance with  
30 **section 45**.

**47. Co-ordinator to consult specialist assessors**—The Co-ordinator must assess the needs of a proposed care recipient in consultation with—

- 35 (a) The specialist assessor or assessors who assessed the care recipient's condition under **Subpart 1**; and
- (b) The care manager of the proposed care recipient.

**48. Co-ordinator to consult with family members of proposed care recipient**—(1) During the needs assessment process, the Co-ordinator must make all reasonable efforts to  
40 consult with the following:

- (a) The proposed care recipient:
  - (b) Any welfare guardian of the proposed care recipient:
  - (c) If the proposed care recipient is a child or young person, each parent or guardian of the child or young person:
  - (d) If the proposed care recipient is a child or young person who is not residing with any of his or her parents or guardians, any person—
    - (i) With whom the care recipient is living; and
    - (ii) Who has had the care of the care recipient for a period of not less than 6 months immediately before the application was made:
  - (e) The principal caregiver of the proposed care recipient:
  - (f) Members of the proposed care recipient's family or whanau:
  - (g) Any friend of the care recipient:
  - (h) Any lawyer of the proposed care recipient.
- (2) The purpose of consultation under subsection (1) is to enable the Co-ordinator—
- (a) To understand the proposed care recipient's history, cultural identity, personal characteristics, aptitudes, and needs; and
  - (b) To ascertain the level of support for the proposed care recipient in the community; and
  - (c) To ascertain the views of those consulted on the care proposed for the proposed care recipient; and
  - (d) To consult on any other matter that the Co-ordinator considers relevant.

**49. Case conferences**—The Co-ordinator may, if the Co-ordinator considers it appropriate to do so, discharge his or her obligations under section 48 by inviting the persons specified in subsection (1) of that section and the proposed care recipient's care manager to a conference.

**50. Cultural assessment**—(1) The Co-ordinator must try to identify the proposed care recipient's culture, ethnicity, language, and any religious or ethical beliefs.

(2) If the proposed care recipient is Maori, the Co-ordinator must try to obtain the views of any Maori organisation concerned with, or interested in, the care of persons who have an intellectual disability.

*Consideration of Compulsory Care Order*

**51. Co-ordinator to consider alternatives to compulsory care**—(1) During the needs assessment process



for a proposed care recipient, the Co-ordinator must consider whether it is practicable to make arrangements for the support and care of the proposed care recipient without a compulsory care order.

- 5 (2) In considering the matter specified in subsection (1), the Co-ordinator must assess the degree of danger that the proposed care recipient poses to the health or safety of that proposed care recipient and of others, and find out if there are effective ways of managing that risk without applying for a compulsory  
10 care order.

**52. Co-ordinator to decide whether to apply for compulsory care order—**(1) When the matters specified in paragraphs (a) and (b) of section 44 have been assessed, the Co-ordinator must decide whether to apply for a compulsory care  
15 order for that proposed care recipient.

(2) When the Co-ordinator has made a decision under subsection (1), the Co-ordinator must notify in writing the following persons of the decision:

- (a) The proposed care recipient:  
20 (b) Any welfare guardian of the proposed care recipient:  
(c) If the proposed care recipient is a child or young person, each parent or guardian of the child or young person:  
(d) If the proposed care recipient is a child or young person who is not residing with any of his or her parents or  
25 guardians, any person—  
(i) With whom the care recipient is living; and  
(ii) Who has had the care of the care recipient for a period of not less than 6 months immediately before the application was made:  
30 (e) The principal caregiver of the proposed care recipient:  
(f) Any friend of the proposed care recipient:  
(g) Any lawyer of the proposed care recipient:  
(h) The care manager of the proposed care recipient:  
(i) The responsible district inspector:  
35 (j) The applicant who applied for that proposed care recipient's assessment under Subpart 1.

(3) The Co-ordinator must sign and date a notice given under subsection (2).

**53. Application to review decision not to apply for compulsory care order—**(1) If the Co-ordinator has decided  
40 not to apply for a compulsory care order in respect of a proposed care recipient, the person who applied for that

proposed care recipient's assessment under **Subpart 1** may apply to a Family Court for a review of the Co-ordinator's decision.

(2) On an application under **subsection (1)**, the Court may direct the Co-ordinator to reconsider his or her decision, and give any directions that the Court thinks appropriate for that purpose. 5

#### *Care Plans*

**54. Care plan to be prepared for care recipient**—(1) If the care manager of a proposed care recipient is notified, under **section 52 (2)**, that the Co-ordinator has decided to apply for a compulsory care order for the care recipient, the care manager must arrange for the preparation of a care plan for the care recipient. 10

(2) The care plan must be approved by the Co-ordinator.

**55. Care plan to identify personal needs of care recipients**—(1) Every care plan must identify the following matters: 15

(a) The social, cultural, and spiritual needs of the proposed care recipient:

(b) Any medical or psychological treatment that the proposed care recipient requires: 20

(c) Any requirements for medication needed to manage the proposed care recipient's condition:

(d) The proposed care recipient's propensity for dangerous behaviour:

(e) Any aptitudes or skills of the care recipient that should, if practicable, be maintained and encouraged: 25

(f) Any special concerns or aversions of the care recipient:

(g) Any special dietary needs of the care recipient:

(h) Any other special needs of the care recipient.

(2) Every care plan must indicate the extent to which, and the manner in which, the needs identified under **subsection (1)** can be met. 30

(3) Every care plan must deal with the kind of supervision the proposed care recipient requires to avoid danger to the health or safety of the care recipient and of others. 35

(4) If it is proposed that the proposed care recipient receive supervised care, the care plan may specify any of the following matters:

(a) The kinds of programmes or facilities that the care recipient may be required to attend: 40

(b) The person or persons with whom the care recipient may be required to live.

**56. Care programme**—Every care plan must set out a care programme for the proposed care recipient that provides for the following matters:

- 5 (a) The objectives of the care proposed to be provided to the proposed care recipient, and the approach or approaches to be followed in achieving those objectives:
- (b) The general nature of the care proposed to be provided to the proposed care recipient:
- 10 (c) The degree of security required for the care of the care recipient and for the protection of others.

**57. Other matters**—(1) A care plan may contain any other matters that the care manager or the Co-ordinator considers should be included in the care plan.

- 15 (2) Subsection (1) is subject to section 54 (2).

SUBPART 3—INTERIM ORDER BY FAMILY COURT IN RESPECT OF  
PROPOSED CARE RECIPIENTS

**58. Family Court may order interim stay in facility**—

20 (1) A Family Court may, on an application by the Co-ordinator, make an interim order requiring a proposed care recipient to stay in a facility if the Court is satisfied that—

- (a) The specialist assessor or assessors who have conducted, or are conducting, the assessment examination under section 38 of the proposed care recipient—
  - 25 (i) Have assessed the proposed care recipient as a person who has an intellectual disability and is in need of compulsory care; or
  - (ii) Have not yet commenced or completed the assessment, but that it is very likely that the proposed care recipient has an intellectual disability and is in need of compulsory care; and
- 30 (b) There are reasonable grounds for believing that it would be impractical or unsafe to conduct or continue the assessment without requiring the proposed care recipient to stay in a facility; and
- 35 (c) It is in the interests of the proposed care recipient or in the public interest to do so.

40 (2) A Family Court may, on an application by the Co-ordinator, make an interim order requiring a proposed care recipient in respect of whom a compulsory care order has been sought to stay in a facility if the Court is satisfied that—

- (a) The specialist assessor or assessors who have conducted the assessment examination of the proposed care recipient, under section 38, have assessed the proposed care recipient as a person who has an intellectual disability and is in need of compulsory care; and 5
- (b) There is a real risk that the proposed care recipient will harm himself or herself or others if the proposed care recipient is not required to stay in a facility while the application for a compulsory care order in respect of the proposed care recipient is pending. 10

**59. Application by Co-ordinator**—(1) The Co-ordinator may apply for an interim order under section 58 without notice.

(2) The Co-ordinator's application must be accompanied by—

- (a) An affidavit sworn by the Co-ordinator setting out the Co-ordinator's reasons for seeking the order; and 15
- (b) A report by a specialist assessor designated to conduct the assessment of the proposed care recipient for whom the order is sought; and
- (c) A certificate by the responsible district inspector that the application is properly made. 20

**60. Persons on whom interim order to be served**—

(1) As soon as practicable after the Court makes an interim order, under section 58, in respect of a proposed care recipient, the Co-ordinator must serve a copy of the order on the following persons: 25

- (a) The proposed care recipient:
- (b) Any welfare guardian of the proposed care recipient:
- (c) If the proposed care recipient is a child or young person, each parent or guardian of the child or young person: 30
- (d) If the care recipient is a child or young person who is not residing with any of his or her parents or guardians, any person—
  - (i) With whom the care recipient is living; and
  - (ii) Who has had the care of the care recipient for a period of not less than 6 months immediately before the application was made: 35
- (e) The principal caregiver of the proposed care recipient:
- (f) Any lawyer of the proposed care recipient:
- (g) The applicant who applied to have the proposed care recipient assessed under Subpart 1: 40
- (h) The specialist assessor designated to conduct the assessment of the proposed care recipient:

(i) The district inspector who gave the certificate under section 59.

5 (2) If a person cannot be served with a copy of an order in accordance with subsection (1), the Family Court may, on such terms and conditions as it thinks fit, dispense with service on that person.

**61. Cancellation or variation of interim order—**

10 (1) Every person served, or entitled to be served, under section 60, with an interim order may apply to the Court for the cancellation or variation of the order.

(2) The Co-ordinator may apply at any time without notice for the cancellation or variation of the order.

(3) The Court may, on an application under this section, cancel or vary an interim order.

15 **62. Duration of interim order—**An interim order made under section 58 in respect of a proposed care recipient expires if 1 of the following events occurs:

20 (a) The Co-ordinator receives a report under section 41 about the proposed care recipient, and that report indicates that the proposed care recipient has not been assessed as a person who has an intellectual disability and is in need of compulsory care:

25 (b) Three days have elapsed since the completion of the needs assessment under Subpart 2 of the proposed care recipient, but the Co-ordinator has not applied for a compulsory care order in respect of the proposed care recipient:

30 (c) Thirty days have elapsed since the commencement of the needs assessment in accordance with section 45, and the needs assessment has not been completed:

(d) The application for a compulsory care order in respect of the proposed care recipient is determined or withdrawn.

SUBPART 4—ASSESSMENTS OF INMATES

35 **63. Superintendent may apply for assessment of inmate—**(1) A superintendent of a prison who has reasonable grounds for believing that an inmate has an intellectual disability and is in need of compulsory care may apply in accordance with Subpart 1 to have the inmate assessed under that Subpart.

40 (2) The superintendent may authorise an officer of the prison to make the application referred to in subsection (1).

**64. Subparts 1 and 2 apply to inmates**—(1) The provisions of Subparts 1 and 2 apply, so far as they are applicable, and with all necessary modifications, to an application referred to in section 63, and to the conduct of any assessment of the inmate or the inmate's care needs. 5

(2) This section is subject to section 65.

**65. Timing for, and place of, assessment examination**—(1) The assessment examination for the purposes of Subpart 1 must take place either—

(a) In the prison within 48 hours after the receipt of the application referred to in section 63; or 10

(b) If that is not practicable, in a facility within 72 hours after the receipt of the application.

(2) If the examination is to be conducted in a facility, the inmate may be taken under the direction of the superintendent of the prison to the facility for the purposes of the examination, and may also be taken back to the prison under the direction of that superintendent. 15

(3) An inmate who is taken to a facility under subsection (2) may not stay in the facility overnight, except in accordance with a notice given under section 66. 20

Cf. 1992, No. 46, s. 45 (4) (a)–(c)

**66. Inmate may have to stay in facility**—(1) The Coordinator may notify the appropriate superintendent that the inmate must stay in a specified facility during 1 or more of the following periods: 25

(a) The period while the inmate is assessed under Subpart 1:

(b) The period while the needs assessment of the inmate is conducted under Subpart 2:

(c) The period while an application for a compulsory care order in respect of the inmate is pending before a Family Court. 30

(2) Unless notice is given under subsection (1), an inmate who is being assessed in a facility continues to be in the legal custody of the superintendent concerned, even though the inmate is absent from the prison. 35

(3) During the period or periods specified in a notice under subsection (1), the inmate to whom the notice relates ceases to be in the legal custody of the superintendent concerned.

Cf. 1992, No. 46, s. 45 (3) (c) (ii), (d)

40

**67. Inmates to appear in court**—The fact that an inmate who is charged with, or convicted of, an offence is also a care recipient does not—

- 5 (a) Prevent the inmate from being taken to the trial or hearing of that offence or to any sentencing for that offence or to any hearing of an appeal in respect of that offence; or
- (b) Operate to delay any trial, hearing, or sentencing referred to in paragraph (a).
- 10 Cf. 1992, No. 46, s. 45 (5)

PART 5

COMPULSORY CARE ORDERS

SUBPART 1—COMPULSORY CARE ORDERS

*Applications for Compulsory Care Orders*

15 **68. Matters to be set out in application**—(1) When the Co-ordinator applies for a compulsory care order for a proposed care recipient, the Co-ordinator must support the application by an affidavit that sets out the Co-ordinator's reasons for considering that the proposed care recipient has an

20 intellectual disability and is in need of compulsory care.

(2) Every application under subsection (1) must be accompanied by the following:

- (a) The care plan completed, under section 54, for the proposed care recipient:
- 25 (b) The care programme completed, under section 56, for the proposed care recipient:
- (c) Every relevant report prepared by a specialist assessor on the proposed care recipient during the assessment of the proposed care recipient under Part 4.

30 *Visit by Judge*

**69. Judge to examine proposed care recipient**—(1) If an application is made for a compulsory care order for a proposed care recipient, a Family Court Judge must examine the proposed care recipient as soon as practicable and in no case

35 later than 14 days after the application is filed in the Court.

(2) Subsection (1) does not prevent a Family Court Judge from completing an examination of a proposed care recipient under that subsection later than 14 days after the filing of the application in respect of the proposed care recipient.

40 (3) The examination must be conducted—

- (a) At the proposed care recipient's place of residence, or at the facility where the proposed care recipient is staying; or
- (b) If that is not practicable, at the nearest practicable place.
- (4) Before examining the proposed care recipient, the Judge must (so far as that is appropriate and can be done)— 5
- (a) Identify himself or herself to the proposed care recipient; and
- (b) Explain to the proposed care recipient the purpose of the visit; and 10
- (c) Discuss the proposed care recipient's current situation and the effects that a compulsory care order would have on that situation; and
- (d) Obtain the proposed care recipient's views on the matters discussed under paragraph (c). 15
- (5) As well as examining the proposed care recipient, the Judge must consult with the Co-ordinator, and with at least 1 specialist assessor involved in the case, and may consult with any other person that the Judge thinks fit concerning the proposed care recipient's condition. 20
- Cf. 1992, No. 46, s. 18 (1)-(4)

**70. Visiting Judge may order withdrawal of application**—If the Judge is satisfied that the proposed care recipient does not require a compulsory care order, the Judge may order the Co-ordinator to withdraw the application for the compulsory care order, and may cancel any interim order made under section 58. 25

Cf. 1992, No. 46, s. 18 (5)

*Making Compulsory Care Order*

**71. Visiting Judge, wherever possible, to hear application**—(1) The Judge who examines a proposed care recipient under section 69 must, wherever possible, conduct any hearing of the application for a compulsory care order in respect of that proposed care recipient. 30

(2) An application for a compulsory care order— 35

(a) May not be heard until the proposed care recipient has been examined by a Judge in accordance with section 69; but

(b) May be heard immediately after that examination.

Cf. 1992, No. 46, s. 18 (6) 40



**72. Court to consider proposed care recipient's condition**—(1) On an application for a compulsory care order, the Family Court must determine whether or not the proposed care recipient has an intellectual disability and is in need of compulsory care.

5

(2) If the Court considers that the proposed care recipient is not a person who has an intellectual disability and is in need of compulsory care, it must cancel any interim order made under section 58.

10

(3) If the Court considers that the care recipient has an intellectual disability and is in need of compulsory care, it must determine whether or not, having regard to all the circumstances of the case, it is necessary to make a compulsory care order.

15

Cf. 1992, No. 46, s. 27

**73. Jurisdiction to make compulsory care order**—The Family Court may, on an application of the Co-ordinator, make a compulsory care order in respect of a proposed care recipient if the Court is satisfied that the proposed care recipient—

20

(a) Has an intellectual disability and is in need of compulsory care; and

(b) Has been assessed under Part 4; and

(c) Is to receive care under a care programme completed under section 56.

25

*Secure Care or Supervised Care?*

**74. Level of care**—(1) A compulsory care order for a civil care recipient must state whether the care recipient must receive supervised care or secure care.

30

(2) If a civil care recipient who requires care in a facility can be appropriately placed in a facility that is not a secure facility, the Court may not order that the care recipient receive secure care.

35

(3) Subsection (2) does not apply if the Court considers that care for the care recipient outside a secure facility would pose a serious danger to the health or safety of the care recipient or of others.

*Term of Compulsory Care Order*

**75. Term of compulsory care order**—(1) Every compulsory care order lasts for the term specified in the order.

40

(2) The term specified under subsection (1) may not be longer than 3 years.

(3) The term specified in the order may be extended under section 115.

*Variation of Compulsory Care Order*

**76. Co-ordinator may seek variation of compulsory care order**—(1) If the Co-ordinator, after consultation with a care recipient's care manager, reaches the view that a variation of the care recipient's compulsory care order is desirable, the Co-ordinator may apply to the Family Court for a variation of the order. 5

(2) The Court may, on an application under subsection (1), vary a compulsory care order. 10

**77. Care plan may be varied**—The Co-ordinator and the responsible care manager of a care recipient may from time to time vary the care plan of the care recipient, but—

(a) No variation may be inconsistent with the care recipient's court order; and 15

(b) No variation of the care programme included in the care plan is effective without the approval of the Family Court.

SUBPART 2—REVIEW OF COMPULSORY CARE ORDER AND PROGRAMME BY FAMILY COURT 20

**78. Co-ordinator to report to Family Court on appropriateness of order and plan**—(1) Six months after the date of a compulsory care order, the Co-ordinator must present a report to the Family Court on the continued appropriateness of the contents of the care recipient's court order and care programme. 25

(2) The report presented under subsection (1) must be accompanied by—

(a) A copy of the most recent certificate under section 109 as to the care recipient's condition; and 30

(b) Copies of any relevant reports from the specialist assessor who gave that certificate and other specialist assessors involved in the case.

(3) Despite subsection (1), if a care recipient's court order lasts for not more than 6 months, then the report under that subsection is due not later than 2 months after the date of that order. 35

(4) If the Co-ordinator has applied, or is about to apply, to the court for the cancellation of a care recipient's compulsory care order, the Co-ordinator is not required to present a report under subsection (1). 40

**79. Co-ordinator must send copy of report to certain persons**—(1) At the same time that the Co-ordinator presents a report under section 78, the Co-ordinator must give or send a copy of that report to the following persons:

- 5 (a) The care recipient:  
(b) The care recipient's care manager:  
(c) If the care recipient is a child or young person, each parent or guardian of the child or young person:  
(d) If the care recipient is a child or young person who is not  
10 residing with any of his or her parents or guardians, any person—  
(i) With whom the care recipient is living in a place other than a facility; and  
(ii) Who has had the care of the care recipient for a  
15 period of not less than 6 months immediately before the application was made:  
(e) Any welfare guardian of the care recipient:  
(f) Any lawyer of the care recipient:  
(g) The care recipient's principal caregiver:  
20 (h) The specialist assessor who gave the certificate referred to in section 78 (2) (a):  
(i) The responsible district inspector:  
(j) In the case of a special care recipient, the Director-General.  
25 (2) A person who receives, or is entitled to receive, a report under subsection (1) may make a written submission on the report to the Family Court.  
(3) At the time that the Co-ordinator gives or sends, in accordance with subsection (1), the report to the persons specified  
30 in that subsection, the Co-ordinator must provide each of those persons with written advice of the right to make a submission under subsection (2).

**80. Family Court to review order and plan**—On receipt of the Co-ordinator's report, under section 78, on a court order  
35 and care programme, the Family Court must review the contents of the order and the care programme.

**81. Family Court may call for reports**—For the purposes of a review under section 80, the Court may call for reports from the Co-ordinator, the care manager, the responsible district  
40 inspector, or any specialist assessor concerned in the case, and may require any of those persons to testify and to produce documents.

**82. Family Court may make recommendations**—On concluding a review under section 80, the Family Court may make such recommendations as it considers appropriate to the Director-General or the Co-ordinator or the care manager.

## PART 6

5

## STATUS AND RIGHTS OF CARE RECIPIENTS

## SUBPART 1—GENERAL STATUS AND SPECIFIC RIGHTS

*Status Generally*

**83. Requirement to accept care**—(1) The compulsory care of a care recipient is entrusted to a care manager designated by the Co-ordinator. 10

(2) A care recipient must accept the care properly given to the care recipient under the care recipient's court order or the care recipient's care plan.

(3) A care recipient must comply with every lawful direction given by the care recipient's Co-ordinator or care manager. 15

*Specific Rights of Care Recipients*

**84. Care recipients are consumers under Code of Health and Disability Services Consumers' Rights**—Every care recipient is a disability services consumer for the purposes of the Code of Rights, and accordingly has all the rights under that Code. 20

**85. General rights to information**—(1) As soon as a court order (as defined in section 17) is made in respect of a care recipient, the care recipient's care manager must— 25

(a) Explain to the care recipient, in a manner that the care recipient is most likely to understand, the care recipient's rights under this Act, including, so far as applicable, the rights specified in subsection (2); and

(b) Give a guardian of the care recipient or, if the care recipient does not have a guardian, the care recipient's principal caregiver a written statement of the care recipient's rights. 30

(2) A care recipient's care manager must keep the care recipient informed, in a manner that the care recipient is most likely to understand, of his or her rights as a care recipient, and, in particular, about— 35

(a) The care recipient's legal status as a care recipient; and

(b) The care recipient's right to have his or her condition reviewed by a specialist assessor in accordance with section 107; and 40

(c) The care recipient's right to seek a judicial inquiry under section 131; and

(d) The functions and duties of district inspectors designated under section 178.

5 Cf. 1992, No. 46, s. 64

**86. Respect for cultural identity**—Every care recipient is entitled to be dealt with in a manner that accords with the spirit and intent of section 27.

Cf. 1992, No. 46, s. 65

10 **87. Medical treatment**—Every care recipient is entitled to medical treatment and other health care appropriate to his or her condition.

Cf. 1992, No. 46, s. 66

15 **88. Rights in case of visual or audio recording**—  
(1) Every care recipient is entitled to be informed if it is intended to make or use a videotape or other visual or audio recording of the following matters:

(a) An interview with the care recipient:

(b) An aspect of the care of the care recipient.

20 (2) Nothing referred to in subsection (1) may be done without the prior consent of the care recipient or a guardian of the care recipient or, if the care recipient is dead, the care recipient's personal representative.

Cf. 1992, No. 46, s. 68

25 **89. Right to independent health and disability advice**—  
(1) Every care recipient is entitled to seek a consultation with a specialist assessor of his or her own choice for the purpose of obtaining a second opinion about the care recipient's condition.

30 (2) If the specialist assessor agrees to the consultation, the specialist assessor must be permitted access to the care recipient when he or she requests to see the care recipient.

Cf. 1992, No. 46, s. 69

35 **90. Right to legal advice**—(1) Every care recipient is entitled to request a lawyer to advise the care recipient on his or her status and rights as a care recipient, or on any other legal issue.

(2) If the lawyer agrees to act for the care recipient, the lawyer must be permitted access to the care recipient when he or she requests to see the care recipient.

Cf. 1992, No. 46, s. 70

**91. Right to company**—(1) Every care recipient is entitled to the company of others. 5

(2) Subsection (1) is subject to section 96.

**92. Right to receive visitors and make telephone calls**—  
(1) Every care recipient is entitled, at reasonable times and at reasonable intervals, to receive visitors and to make telephone calls, except where the care manager has reasonable grounds for believing that a visit or call would be detrimental to the interests and care of the care recipient. 10

(2) Nothing in this section limits anything in section 89 or section 90. 15

Cf. 1992, No. 46, s. 72

**93. Right to receive mail**—(1) Every care recipient is entitled to receive, unopened, every item of mail addressed to the care recipient.

(2) The care manager may, with the approval of the Co-ordinator, direct that any item of mail addressed to a care recipient be opened and checked if there are reasonable grounds for believing that the receipt of the item by the care recipient could be detrimental to the interests and care of the care recipient. 20 25

(3) If, on checking an item under subsection (2), it is considered that the receipt of the item by the care recipient could be detrimental to the interests and care of the care recipient, the care manager may, with the approval of the Co-ordinator, direct that it be withheld from the care recipient. 30

(4) Despite subsection (3), no item of mail addressed to a care recipient may be withheld from the care recipient if it is sent by or on behalf of any of the following persons:

- (a) A member of Parliament:
- (b) A Judge or officer of a court, or a member or officer of another judicial body: 35
- (c) An Ombudsman:
- (d) The Privacy Commissioner:
- (e) The Health and Disability Commissioner:
- (f) A Human Rights Commissioner: 40
- (g) In the case of a care recipient who is a child or young person, the Commissioner for Children:

- (h) The Director-General of Health:
- (i) A district inspector:
- (j) The care manager:
- (k) A lawyer:
- 5 (l) A specialist assessor from whom the care recipient has sought a second opinion about the care recipient's condition.

Cf. 1992, No. 46, ss. 73, 123

10 **94. Right to send mail**—(1) Every care recipient is entitled to the prompt dispatch, unopened, of every item of mail put out by the care recipient for posting.

(2) The care manager may direct that an item of mail put out by a care recipient for posting be opened and checked if there are reasonable grounds for believing that the dispatch of the  
15 item could be detrimental to the interests and care of the care recipient.

(3) If, on checking an item under subsection (2), it is considered that the dispatch of the item could be detrimental to the interests and care of the care recipient, the care manager may  
20 direct that it be withheld from posting.

(4) The care manager must withhold from posting an item of mail put out by a care recipient for posting that is addressed to a person who has notified the care manager that he or she does not wish to receive communications from that care recipient.

25 (5) Despite subsection (3), no item of mail put out by a care recipient for posting may be withheld from posting if it is addressed to 1 or more of the persons described in section 93 (4).

Cf. 1992, No. 46, ss. 73, 124

30 **95. Procedure where mail withheld**—(1) If the care manager withholds an item of mail under section 93, the item must be dealt with as follows:

- (a) If the address of the sender is known to the care manager, it must be returned to the sender:
- (b) If the address of the sender is not known to the care  
35 manager, it must either be—
  - (i) Posted to the responsible district inspector; or
  - (ii) Produced to the responsible district inspector when he or she next visits the facility after the receipt of the item.

40 (2) If the care manager withholds an item of mail under section 94, the item must either be—

- (a) Posted to the responsible district inspector; or

(b) Produced to the responsible district inspector when he or she next visits the facility after the item has been put out for posting.

(3) If an item of mail is withheld under **section 93** or **section 94**, the care recipient must be informed of the fact, unless the care manager is satisfied that to do so would be detrimental to the interests and care of the care recipient. 5

Cf. 1992, No. 46, s. 125

SUBPART 2—SPECIFIC POWERS EXERCISABLE OVER CARE  
RECIPIENTS 10

**96. Isolation**—(1) For the purposes of this section, “isolate”, in relation to a care recipient, means placing the care recipient without others in a room or other area that—

(a) Provides a safe environment for the care recipient throughout the care recipient’s stay in the room or area; but 15

(b) Does not allow the care recipient to leave without help.

(2) A care manager may isolate a care recipient if it is necessary to prevent the care recipient from doing 1 or both of the following: 20

(a) Endangering the health or safety of the care recipient or of others:

(b) Seriously compromising the care and well-being of other persons.

(3) A person who isolates a care recipient— 25

(a) Must ensure that the care recipient is not isolated for longer than is necessary to achieve the purpose of isolating the care recipient; and

(b) Must comply with guidelines issued under **section 181** that are relevant to isolating the care recipient. 30

(4) The following provisions must be followed when a care recipient is isolated:

(a) A care recipient may be isolated only in a room or other area that is specifically designed for the purpose of isolation in accordance with guidelines issued under **section 181**: 35

(b) In cases other than an emergency, isolation may be used only with the authority of the care recipient’s care manager:

(c) In an emergency, a care recipient may be isolated by a person who, under a delegation given by the care recipient’s care manager, has immediate responsibility for the care recipient, but that person 40



must immediately bring the case to the attention of the care manager:

- (d) The duration and circumstances of each episode of isolation must be recorded in a register kept in accordance with guidelines issued under section 181.

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**97. Restraint of care recipients**—(1) A care manager may restrain a care recipient if that is necessary to prevent the care recipient from doing 1 or more of the following:

- (a) Endangering the health or safety of the care recipient or of others:

10

(b) Seriously damaging property:

(c) Seriously compromising the care and well-being of the care recipient or of other care recipients.

(2) A care recipient may not be restrained under subsection (1) by the application of a mechanical restraint if—

15

(a) One or more authorised individuals can personally restrain the care recipient to achieve the purpose for which the care recipient is to be restrained; and

(b) It is reasonably practicable for those individuals to do so.

20

(3) A care manager who restrains a care recipient under subsection (1)—

(a) May not use a greater degree of force, and may not restrain the care recipient for longer, than is required to achieve the purpose for which the care recipient is restrained; and

25

(b) Must comply with guidelines issued under section 181 that are relevant to the restraint of the care recipient.

**98. Enforced medical treatment**—(1) A care recipient can be given medical treatment without the care recipient's consent only if the treatment is authorised by this section or another enactment or a rule of law.

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(2) In an emergency, a care recipient may be given medical treatment if the treatment is immediately necessary—

(a) To save the care recipient's life; or

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(b) To prevent serious damage to the health of the care recipient; or

(c) To prevent the care recipient from causing serious injury to the care recipient or to others.

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(3) A care recipient may be given medication for the purpose of managing the care recipient's condition that gives rise to the care recipient's need for compulsory care if the medication is prescribed—

- (a) In accordance with requirements identified in the care recipient's care plan; and
- (b) With the support of a second opinion given by a medical consultant designated by the Director-General under section 180.

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SUBPART 3—REQUIREMENT TO STAY IN DESIGNATED FACILITIES  
OR PLACES

*Placement of Care Recipients*

**99. Designation notices relating to secure care**—(1) This section applies to every special care recipient and to every civil care recipient who is required to receive secure care.

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(2) Every care recipient to whom this section applies—

- (a) Must stay in a secure facility that the Co-ordinator designates from time to time by written notice given to the care recipient and the care recipient's care manager; and
- (b) May not leave the facility without authority given under this Act.

15

**100. Directions relating to supervised care**—(1) The Co-ordinator may from time to time direct a care recipient who is required to receive supervised care to stay in a designated facility or in a designated place.

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(2) A direction under subsection (1) takes effect when written notice of the direction is given to the care recipient and the care recipient's care manager.

25

(3) A care recipient who is required to receive supervised care may not be directed to stay in a secure facility.

(4) While a direction under subsection (1) is in force, the care recipient to whom the direction relates must stay in the facility or place designated by the direction.

30

(5) If a direction under subsection (1) requires the care recipient to stay in a facility, the care recipient may not leave the facility without authority given under this Act.

*Leave for Civil Care Recipients*

**101. Leave for civil care recipients**—(1) The care manager in charge of a facility may from time to time authorise a civil care recipient who is required to stay in the facility to be on leave from the facility for a period of not more than 3 months on any terms and conditions that the care manager specifies.

35

(2) The care manager may from time to time extend the period of authorised leave for a further period of not more

40

than 3 months; but no care recipient may be absent under this section for a continuous period of more than 6 months.

5 (3) The care manager may, at any time during the period of leave, cancel the leave by notifying the person who has undertaken the care of the care recipient during the period of leave, or, if there is no such person, by notifying the care recipient.

Cf. 1992, No. 46, s. 31

*Leave for Special Care Recipients*

10 **102. Leave for certain special care recipients**—(1) This section applies to a care recipient who is detained in a secure facility—

- (a) As a special care recipient acquitted on account of insanity; or
- 15 (b) As a special care recipient liable to detention under a sentence, other than a sentence of imprisonment for life or a sentence of preventive detention.

20 (2) The Minister may authorise a care recipient to whom this section applies to be on leave from the care recipient's secure facility on any terms and conditions that the Minister specifies, if a specialist assessor certifies that the care recipient is fit to be on leave.

25 (3) The Minister may (at the Minister's discretion) include in the conditions specified under subsection (2) a condition that the care recipient return to the secure facility on a specified date or within a specified period.

30 (4) No care recipient may be on leave, authorised under this section, if the care recipient is charged with, or convicted of, an offence, and a trial or hearing of that offence is to take place or the care recipient is to be sentenced for that offence or an appeal in respect of that offence is pending.

35 (5) The Minister may, at any time during a period of leave authorised under this section, cancel that leave by notifying the person who has undertaken the care of the care recipient during the period of leave, or, if there is no such person, by notifying the care recipient.

Cf. 1992, No. 46, s. 50

40 **103. Director-General may authorise short-term leave**—(1) The Director-General may authorise a special care recipient to be on leave, from the secure facility in which the care recipient is detained, for a period of not more than 7 days

on any terms and conditions that the Director-General specifies.

(2) The power to authorise leave under this section may not be exercised in respect of a care recipient described in section 102 (4). 5

(3) The Director-General may, at any time during a period of leave authorised under this section, cancel that leave by notifying the person who has undertaken the care of the special care recipient during the period of leave, or, if there is no such person, by notifying the care recipient. 10

(4) With the authority of the Director-General and subject to any conditions that the Director-General may impose, the Co-ordinator may exercise in any particular case the powers conferred on the Director-General by this section.

(5) Before the Co-ordinator exercises a power under subsection (4) in respect of a care recipient who, following an application under section 63, has been transferred from a prison, the Co-ordinator must consult with the superintendent of that prison. 15

Cf. 1992, No. 46, s. 52 20

#### SUBPART 4—STATUS OF SPECIAL CARE RECIPIENTS SUBJECT TO SENTENCES

**104. When liability to detention under sentence ceases**—For the purposes of this Act, a care recipient's liability to detention under a sentence ceases— 25

- (a) As determined under section 90 of the Criminal Justice Act 1985; or
- (b) When a direction for release given by the Parole Board under section 97 of that Act comes into effect; or
- (c) When the sentence ceases to run. 30

**105. Relationship between detention in secure facility and sentence**—(1) This section applies to a person who is liable to detention under a sentence, and also liable to detention in a secure facility—

- (a) Following an application under section 63; or 35
- (b) In accordance with an order under section 118 (1) (a) (ii) <sup>9</sup> of the Criminal Justice Act 1985.

(2) The term of a sentence applicable to a person to whom this section applies—

<sup>9</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

- (a) Continues to run while the person is in a secure facility, or is on authorised leave from the secure facility; and
- (b) Ceases to run if he or she escapes from the secure facility before his or her liability to detention under the sentence ceases; and
- 5 (c) Does not begin to run again until the person is retaken.
- (3) The person ceases to be detained as a special care recipient on the date on which he or she ceases to be liable to be detained under any sentence and,—
- 10 (a) If on that date he or she is subject to a compulsory care order as the result of an application under section 63, he or she remains subject to the compulsory care order:
- 15 (b) If on that date he or she is subject to an order under section 118 (1) (a) (iii) <sup>10</sup> of the Criminal Justice Act 1985,—
- (i) He or she is to be treated as being subject to a compulsory care order; and
- (ii) That compulsory care order is to be treated as having been made on that date for a term of 6
- 20 months.

Cf. 1992, No. 46, s. 48

**106. Former care recipients subject to sentence to be taken to prison—**(1) When a person ceases to be a care recipient but does not cease to be liable to detention under a sentence, the person must—

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- (a) Be taken to a prison to undergo the remainder of the sentence; or
- (b) Be otherwise dealt with according to law as if the person had never been a care recipient.
- 30 (2) The Co-ordinator must notify the chief executive of the Department of Corrections about a person to whom subsection (1) applies, and the chief executive must arrange for the person to be taken to a prison within 7 days after the date of the notification.
- 35 (3) For the purposes of this section, “prison” includes a residence for the time being approved under section 142A of the Criminal Justice Act 1985.

Cf. 1992, No. 46, s. 47 (1), (3)

<sup>10</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

## PART 7

## DURATION OF COMPULSORY CARE

## SUBPART 1—CONDITION OF EVERY CARE RECIPIENT TO BE REVIEWED

- 107. Regular clinical reviews of care recipients—**(1) The condition of every care recipient who is subject to a court order must be formally reviewed at the times specified in subsection (2). 5
- (2) The times referred to in subsection (1) are,—
- (a) In respect of the first review—
- (i) If the care recipient is subject to a compulsory care order, not later than 14 days before the Co-ordinator is required, under section 78, to present a report to the Family Court on that order: 10
- (ii) In any other case, not later than 6 months after the date on which the care recipient's court order is made; and 15
- (b) From then on at intervals of not more than 6 months; and
- (c) Not later than 14 days before a care recipient's compulsory care order expires.
- (3) It is the responsibility of the care manager of a care recipient to ensure that the care recipient's condition is reviewed in accordance with subsection (1). 20
- 108. Reviews undertaken by specialist assessors—**(1) A review of a care recipient under section 107 must be conducted by 1 or more specialist assessors designated by the Co-ordinator for the purpose. 25
- (2) When the Co-ordinator designates 2 or more specialist assessors for the purpose of a review under section 107, the Co-ordinator must nominate 1 of those assessors as the assessor who is principally responsible for the conduct of the review. 30
- (3) In reviewing a care recipient under section 107, the specialist assessor or specialist assessors must—
- (a) Examine the care recipient; and
- (b) Consult with other health or disability professionals involved in the care of the care recipient, and take their views into account when assessing the results of the review of the care recipient's condition. 35
- 109. Specialist assessor to issue certificate—**(1) A review of a care recipient under section 107 is concluded by the issue of a certificate as to whether the status of the care recipient needs to be continued or needs to be changed. 40

(2) The certificate required by subsection (1) must be given by the specialist assessor who is responsible or principally responsible for the conduct of the review.

5 (3) The certificate required by subsection (1) must comply with whichever of the following provisions is relevant:

- (a) Section 112 (which relates to civil care recipients and to care recipients liable to detention under a sentence); or
- 10 (b) Section 118 (which relates to a person who is a special care recipient because of an order made, under the Criminal Justice Act 1985, following a finding that the person is unfit to stand trial); or
- (c) Section 121 (which relates to a person who is a special care recipient because of an order made, under the Criminal Justice Act 1985, following the acquittal of  
15 the person on account of insanity).

**110. Specialist assessor to send certificate and reports to certain persons**—A specialist assessor who has given a certificate, under section 109, on a care recipient must give or send to the care recipient's care manager and to the Co-ordinator, and, in the case of a special care recipient, also to the Director-General, a copy of—

- (a) The certificate; and
- (b) Full particulars of the reasons for his or her opinion on the care recipient's condition; and
- 25 (c) Any relevant reports from other specialist assessors involved in the case.

**111. Care manager to send copy of certificate to certain persons**—On receipt, under section 110, of a certificate on a care recipient, the care manager of the care recipient must give or  
30 send a copy of the certificate to the following persons:

- (a) The care recipient;
- (b) Any welfare guardian of the care recipient;
- (c) If the care recipient is a child or young person, each parent or guardian of the child or young person;
- 35 (d) If the care recipient is a child or young person who is not residing with any of his or her parents or guardians, any person—
  - (i) With whom the care recipient is living in a place other than a facility; and
  - 40 (ii) Who has had the care of the care recipient for a period of not less than 6 months immediately before the application was made;
- (e) The care recipient's principal caregiver:

(f) The responsible district inspector.

SUBPART 2—CHANGE IN STATUS OF CIVIL CARE RECIPIENTS AND  
SPECIAL CARE RECIPIENTS LIABLE TO DETENTION UNDER A  
SENTENCE

*Form of Certificate*

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**112. Form of clinical review certificate for civil care recipients and care recipients liable to detention under sentence**—When a specialist assessor completes a certificate, under section 109, in respect of a civil care recipient or a special care recipient who is liable to detention under a sentence, the specialist assessor must state whether in his or her opinion— 10

(a) The care recipient still needs to be cared for as a care recipient; or

(b) The care recipient no longer needs to be cared for as a care recipient. 15

*Release from Compulsory Care*

**113. Status on expiry of term of compulsory care order**—On the expiry of a compulsory care order the care recipient ceases to be a care recipient under this Act.

**114. Cancellation of court orders of certain care recipients**—(1) If a Family Court is satisfied that a civil care recipient or a special care recipient who is liable to detention under a sentence no longer needs to be cared for as a care recipient, the Court may, on the application of the Co-ordinator, cancel the care recipient's compulsory care order or the care recipient's order made under section 118 (1) (a) (iii) <sup>11</sup> of the Criminal Justice Act 1985. 20 25

(2) The Co-ordinator—

(a) May make an application under subsection (1) at any time; and 30

(b) Must, as soon as practicable after a certificate under section 109 states that a care recipient no longer needs to be cared for as a care recipient, make an application under subsection (1) in respect of that care recipient's compulsory care order. 35

<sup>11</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)



*Continuation of Compulsory Care*

**115. Extension of compulsory care order**—A Family Court may, on the application of the Co-ordinator, extend the term of a care recipient's compulsory care order.

5     **116. Court may defer expiry of order if application for extension pending**—(1) If a care recipient's order is due to expire at any time when an application, under section 115, to extend the term of that order is pending before a Family Court, the Court may defer the expiry of the order by  
10 specifying a date as the last day of a period that, in the opinion of the Court, is sufficient for the application to be heard and determined.

(2) The Co-ordinator may apply without notice for an order, under subsection (1), to defer the expiry of a compulsory care  
15 order.

(3) As soon as the Court makes an order under subsection (1), the Co-ordinator must serve a copy of the order on every person who is entitled to be served with a copy of the application under section 115.

20 (4) Every person served, or entitled to be served, under subsection (3) with a copy of an order under subsection (1) may apply to the Court for the cancellation or variation of the order.

**117. Co-ordinator and Court to have regard to specialist assessor's certificate**—(1) In deciding whether to  
25 apply for a cancellation of a care recipient's court order, or for an extension of the term of a care recipient's compulsory care order, the Co-ordinator must have regard to the most recent certificate given, under section 109, for that care recipient.

(2) In deciding whether to cancel, or to extend the term of, a  
30 care recipient's court order, the Court must have regard to the most recent certificate given, under section 109, for that care recipient.

SUBPART 3—STATUS OF CERTAIN SPECIAL CARE RECIPIENTS

*Special Care Recipients Detained Because Unfit to Stand Trial*

35     **118. Form of clinical review certificate for special care recipients detained because unfit to stand trial**—(1) This section applies to a person who is detained as a special care recipient because of an order, made under the Criminal Justice Act 1985, following a finding that the person is unfit to stand  
40 trial.

(2) When a specialist assessor completes a certificate, under section 109, for a person to whom this section applies, the assessor must state in respect of the person 1 of the following opinions:

- (a) The person is no longer unfit to stand trial:
- (b) The person is still unfit to stand trial and it is necessary, in 5  
the person's own interests or in the interests of the  
safety of any person, class of person, or the public,  
that the person continue to be cared for as a special  
care recipient:
- (c) The person is still unfit to stand trial, but it is no longer 10  
necessary, in the person's own interests or in the  
interests of the safety of any person, class of person,  
or the public, that the person continue to be cared for  
as a special care recipient.

**119. If special care recipient considered fit to stand 15  
trial, Attorney-General to be notified—**(1) If a certificate in  
the form required by section 118 states that a person is no longer  
unfit to stand trial, the Co-ordinator must forward the  
certificate to the Attorney-General for the purposes of  
section 116A <sup>12</sup> of the Criminal Justice Act 1985. 20

(2) In forwarding a certificate to the Attorney-General, the  
Co-ordinator may add any comments or recommendations  
that the Co-ordinator considers appropriate.

**120. Where person considered suitable for care as civil 25  
care recipient, Ministers to be notified—**(1) If a certificate  
in the form required by section 118 states that a person is still  
unfit to stand trial, but that it is no longer necessary that the  
person be cared for as a special care recipient, the Co-ordinator  
must forward the certificate to the Minister and the Attorney-  
General for the purposes of section 116A <sup>13</sup> of the Criminal Justice 30  
Act 1985.

(2) In forwarding a certificate to the Minister, the Co-  
ordinator may add any comments or recommendations that  
the Co-ordinator considers appropriate.

<sup>12</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

<sup>13</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

*Special Care Recipients Detained Because Acquitted on Account of Insanity*

5 **121. Form of clinical review certificate for special care recipients detained because acquitted on account of insanity**—(1) This section applies to a person who is detained as a special care recipient because of an order made under the Criminal Justice Act 1985, following the acquittal of the person on account of insanity.

10 (2) When a specialist assessor completes a certificate, under section 109, for a person to whom this section applies, the assessor must state in respect of the person 1 of the following opinions:

15 (a) It is still necessary, in the person's own interests or in the interests of the safety of any person, class of person, or the public, that the person continue to be cared for as a special care recipient:

(b) It is no longer necessary, in the person's own interests or in the interests of the safety of any person, class of person, or the public, that the person continue to be cared for as a special care recipient.

20 **122. Where person considered not to require further care as special care recipient**—(1) If a certificate in the form required by section 121 states the opinion specified in subsection (2) (b) of that section, the Co-ordinator must forward the certificate to the Minister for the purposes of section 117<sup>14</sup> of the  
25 Criminal Justice Act 1985.

(2) In forwarding a certificate to the Minister, under subsection (1), the Co-ordinator may add any comments or recommendations that the Co-ordinator considers appropriate.

30 *Change of Status from Special Care Recipient to Civil Care Recipient*

**123. Change from special care recipient to civil care recipient**—(1) This section applies to any person who, as a result of a direction given under the Criminal Justice Act 1985 or under sections 134 or 135 of this Act, ceases to be a special care  
35 recipient and becomes a civil care recipient.

(2) A person to whom subsection (1) applies is to be treated as if he or she were subject to a compulsory care order for a term of 6 months, commencing on the date on which the direction under the Criminal Justice Act 1985 was given.

<sup>14</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

(3) Despite subsection (2), a person to whom this section applies must be reviewed under section 107 as soon as practicable after the direction under the Criminal Justice Act 1985 is given.

(4) If the review conducted in accordance with subsection (3) is completed by a certificate to the effect that the person to whom this section applies no longer needs to be cared for as a care recipient, the person must be released from every restraint under this Act. 5

## PART 8

### INSPECTIONS AND INQUIRIES 10

#### SUBPART 1—INSPECTIONS, INVESTIGATIONS, AND INQUIRIES BY DISTRICT INSPECTORS

##### *Inspections*

**124. Visits by district inspectors—**(1) A district inspector must, at least 4 times a year at regular intervals, visit each facility— 15

(a) That is in the locality for which the district inspector is responsible; and

(b) In which care recipients are required to receive care.

(2) The district inspector may, without previous notice, visit a facility as often as the district inspector thinks fit. 20

(3) The district inspector may visit a facility at any time and for any length of time that the district inspector thinks fit.

(4) The Co-ordinator may ask, or permit, a suitably qualified health or disability professional to accompany the district inspector on a particular visit to a facility. 25

(5) The district inspector may obtain advice on a particular matter from a specialist assessor appointed for the purpose by the Co-ordinator, and that specialist assessor has, for that purpose, the powers of the district inspector to visit and inspect facilities. 30

Cf. 1992, No. 46, s. 96

**125. Inspectors' access to persons and documents—**

(1) A district inspector who visits a facility for the purposes of this Act must be given access to every part of the facility and to every person in it, whether or not that person is a care recipient under this Act. 35

(2) The care manager must present to the district inspector the following documents:

(a) Every record relating to a care recipient, including the care recipient's court order and care plan: 40

(b) Every item of mail withheld by the care manager under section 93 or section 94.

Cf. 1992, No. 46, s. 97

*Complaints about Breaches of Rights*

5     **126. Complaint of breach of rights**—(1) A care recipient may complain to the responsible district inspector about a breach of the care recipient's rights under this Act.

(2) Any person may complain on behalf of the care recipient.

10    (3) A care manager or Co-ordinator who receives a complaint about a breach of the care recipient's rights under this Act must refer the complaint to the responsible district inspector.

(4) The responsible district inspector must notify the Health and Disability Commissioner under the Health and Disability Commissioner Act 1994 of every complaint that concerns a  
15 breach of the Code of Rights.

**127. Investigation by district inspector**—(1) If a complaint made or referred to the district inspector under section 126 is not a complaint that concerns a breach of the Code of Rights, the district inspector must investigate the complaint.

20    (2) In investigating a complaint, the district inspector must try to talk with the care recipient, any person who complained on behalf of the care recipient, the care manager, and everyone else involved in the case.

(3) If, after investigating the complaint, the district inspector  
25 is satisfied that the complaint has substance, the district inspector must—

- (a) Conduct an inquiry under section 130 into the complaint; or
- (b) Report the matter together with any recommendations to the care manager.

30     **128. Duty of care manager to put things right**—On receiving a report under section 127, the care manager must take all steps necessary to correct every deficiency identified in the report.

**129. Care recipient to be informed of outcome of investigation**—(1) On concluding an investigation under section 127, the district inspector must report the outcome of the investigation to—  
35

- (a) The care recipient whose rights were in issue in the investigation; and
- 40    (b) Any person who complained on behalf of the care recipient.

(2) If the care recipient or the person who complained on behalf of the care recipient is not satisfied with the outcome of the complaint, he or she may request the Director-General to examine the complaint, and the Director-General must consider if further investigation is warranted. 5

Cf. 1992, No. 46, s. 75

*Inquiries by District Inspectors*

**130. Inquiries by district inspector**—(1) Every district inspector may inquire into—

- (a) An alleged breach of this Act or of regulations made under this Act, or an alleged breach of duty on the part of a director, employee, or agent of a service: 10
- (b) Whether a care recipient's condition is being reviewed in accordance with section 107:
- (c) Any other matter relating to a care recipient or the management of a service. 15

(2) The Director-General may direct a district inspector who is responsible for a locality within the Co-ordinator's area to conduct an inquiry under subsection (1), and that district inspector must comply with that direction. 20

(3) Despite subsections (1) and (2), no district inspector may inquire into an alleged breach of the Code of Rights.

(4) For the purpose of conducting an inquiry under this Act, a district inspector has the same powers and authority to summon witnesses and receive evidence as are conferred on commissions of inquiry by the Commissions of Inquiry Act 1908; and the provisions of that Act, except sections 11 and 12 (which relate to costs), apply accordingly. 25

(5) As soon as practicable after finishing an inquiry under this section, a district inspector must send a full report of the inquiry to the Co-ordinator. 30

Cf. 1992, No. 46, s. 95

SUBPART 2—INQUIRY BY HIGH COURT JUDGE

**131. Judge may call for report on care recipient or summon care recipient**—(1) A High Court Judge may make an order directing a district inspector or 1 or more other persons— 35

- (a) To visit and examine a care recipient who is detained in a facility; and
- (b) To inquire into and report on any matter relating to that care recipient that the Judge specifies. 40

(2) Whether an order under subsection (1) has been made or not, a High Court Judge may make an order directing a care manager to bring a care recipient for whom the care manager is responsible before the Judge in open Court or in Chambers, for examination at a time specified in the order.

(3) An order under subsection (1) or (2) may be made on the Judge's own initiative or on the application of any person.

Cf. 1992, No. 46, s. 84 (1), (2)

**132. Judge may summon witnesses**—For the purposes of an examination of a person under section 131 (2), the Judge may summon any specialist assessor or other witness to testify on oath in respect of any matter involved in the examination, and to produce any relevant documents.

Cf. 1992, No. 46, s. 84 (7)

**133. Judge may release civil care recipient**—After the examination of a civil care recipient under section 131 (2), the Judge may order that the care recipient cease to be a care recipient if the Judge is satisfied—

(a) That the care recipient is detained illegally as a care recipient; or

(b) That the care recipient no longer needs to be cared for as a care recipient.

Cf. 1992, No. 46, s. 84 (3)

**134. Orders Judge may make in relation to special care recipient detained because unfit to stand trial**—(1) This section applies to a person ("the accused") who is detained as a special care recipient because of an order under the Criminal Justice Act 1985, made following a finding that the accused is unfit to stand trial.

(2) After examining the accused under section 131 (2), the Judge may,—

(a) If the Judge considers that the accused is capable of being tried or committed for trial on the charge or indictment against the accused, direct that the accused be brought before the appropriate court; or

(b) If in the circumstances of the case the Judge considers it proper to do so and the interests of justice so permit, direct that the charge or indictment against the accused be dismissed (whether or not the accused is capable of being tried or committed for trial).

(3) If after examining the accused under section 131 (2), the Judge is satisfied that it is no longer necessary, in the accused's

own interests or in the interests of the safety of any person, class of person, or the public, that the accused continue to be cared for as a special care recipient, the Judge may order that—

- (a) The accused be cared for as a civil care recipient under this Act; or 5
- (b) The accused cease to be a care recipient under this Act. Cf. 1992, No. 46, s. 84 (4)–(6)

**135. Orders Judge may make in relation to special care recipient detained because acquitted on account of insanity**—If after examining a person acquitted on account of insanity under section 131 (2), the Judge is satisfied that it is no longer necessary, in the person's own interests or in the interests of the safety of any person, class of person, or the public, that the person continue to be cared for as a special care recipient, the Judge may order that— 10 15

- (a) The person be cared for as a civil care recipient under this Act; or
- (b) The person cease to be a care recipient under this Act.

**136. Judge may report to Minister**—The Judge may in any case under this Subpart, if the Judge thinks fit, report his or her opinion to the Minister, with any comments and recommendations that the Judge thinks fit. 20

Cf. 1992, No. 46, s. 84 (8)

**137. Other remedies still available**—Nothing in this Subpart prevents the exercise of any other remedy, or the bringing of any proceeding, by or on behalf of any person who is, or is alleged to be, unlawfully detained, confined, or imprisoned. 25

Cf. 1992, No. 46, s. 84 (9) 30

## PART 9

### AUTHORITY TO TAKE AND DETAIN PERSONS

#### *Short-term Detention by Police*

**138. Police may apprehend person in public place appearing to have an intellectual disability and be in need of compulsory care**—(1) This section applies to a person (“the person”) who acts, in a public place, in a manner that gives rise to a reasonable belief that the person may have an intellectual disability and be in need of compulsory care. 35



(2) A member of the police may, if he or she thinks that it would be desirable in the person's own interests or in the interests of the safety of any person, class of person, or the public to do so,—

5 (a) Take the person to a police station, hospital, surgery, facility, or to some other appropriate place; and

(b) Detain the person at that place so that a medical practitioner or psychologist can examine the person.

10 (3) If the medical practitioner or psychologist who examines the person does not consider that there are reasonable grounds for believing that the person may have an intellectual disability and be in need of compulsory care, the person must be released immediately.

15 (4) However, the medical practitioner or psychologist who conducts the examination must apply to the Co-ordinator, in accordance with section 29, for assessment of the person if the medical practitioner or psychologist considers that—

20 (a) There are reasonable grounds for believing that the person may have an intellectual disability and be in need of compulsory care; and

(b) It is desirable in the person's own interests or in the interests of the safety of any person, class of person, or the public that an assessment examination of the person be conducted as a matter of urgency.

25 (5) Detention under this section may last no longer than 6 hours or the time it takes to carry out the actions referred to in this section, whichever is shorter.

Cf. 1992, No. 46, s. 109 (1)–(3)

30 **139. Detention of person to be assessed—**(1) In a case where a medical practitioner or psychologist has applied for an assessment of a person in accordance with section 138 (3), a member of the police may continue to detain the person so that an assessment examination can be conducted, under section 38, to ascertain whether the person has an intellectual disability and is in need of compulsory care.

35 (2) During the period of detention under this section, a member of the police may take the person who is detained to a place nominated by the specialist assessor who is to conduct the assessment examination under section 38.

40 (3) Detention under this section may last no longer than 6 hours or the time it takes to carry out the actions referred to in this section, whichever is shorter.

Cf. 1992, No. 46, s. 109 (4), (5)

*Authority to Detain under Court Orders*

**140. Authority to admit and detain under interim order**—(1) This section applies to an interim order under section 58 requiring a person to stay in a facility.

(2) The person in charge of the facility named in an order to which this section applies has authority— 5

(a) To admit a person to the facility in accordance with the order; and

(b) To take all reasonable steps to detain that person in the facility while the order is in force. 10

Cf. 1992, No. 46, s. 113 (1)

**141. Authority to admit and detain under final orders**—A care manager has authority—

(a) To admit a care recipient to a facility in accordance with the care recipient's court order or a notice of designation given by the Co-ordinator under section 99 (1); and 15

(b) To take all reasonable steps to detain that care recipient in the facility during the period the designation is in force. 20

Cf. 1992, No. 46, s. 113 (2)

*Authority to Take Care Recipients who Escape or Disobey Court Orders*

**142. Meaning of "care recipient who has escaped"**—In sections 143 to 145, the expression "care recipient who has escaped" means a care recipient— 25

(a) Who has left the care recipient's facility without authority; or

(b) Who has failed to return to the care recipient's facility after the expiry of authorised leave; or 30

(c) Who has failed to return to the care recipient's facility after the cancellation of previously authorised leave.

**143. Power to retake care recipient absent without authority**—The Co-ordinator or the care manager of a care recipient who has escaped, or the person to whom the charge of that care recipient has been entrusted during any period of leave, or any member of the police, may retake and return that care recipient to the care recipient's facility or to another facility specified by the Co-ordinator. 35

**144. Warrant to enter and search places to retake escaped care recipients**—(1) A District Court Judge or (if no 40

Judge is available) a Registrar may issue a warrant in the prescribed form authorising any member of the police to search a specified place and take a named person to a facility, if the District Court Judge or Registrar is satisfied that there are reasonable grounds for believing that the person—

- (a) Is a care recipient who has escaped; and
- (b) Is in the place that is to be specified in the proposed warrant.

(2) A warrant under subsection (1) can only be issued on an application, in writing, made on oath by the Co-ordinator or the care manager of the care recipient who has escaped.

(3) A member of the police who executes a warrant under subsection (1) may do so with any assistance from the Co-ordinator or the care recipient's care manager that the member of the police requests.

(4) A warrant authorises the member of the police who is executing it and the Co-ordinator and care manager who may be required to assist the member of the police—

- (a) To enter and search at any time the place specified in the warrant; and
- (b) To remove the care recipient from that place and to take him or her to the care recipient's facility or to another facility specified by the Co-ordinator; and
- (c) To use any reasonable force that may be required to carry out any action referred to in paragraph (a) or (b).

**145. Entry of place without warrant—**(1) A member of the police may enter a place without a warrant if there are reasonable grounds for believing that—

- (a) Entry is necessary in order to retake a care recipient who has escaped; and
- (b) The care recipient is endangering, or there is an imminent risk that the care recipient will endanger, the health or safety of the care recipient or of others.

(2) A member of the police who enters a place under subsection (1) may be accompanied and assisted by the Co-ordinator or by the care recipient's care manager.

(3) A member of the police who enters a place under this section, and the Co-ordinator and care manager who may be required to assist the member of the police, may—

- (a) Enter and search the place, at any time; and
- (b) Use any reasonable force that may be required to enter or search the place or to take and remove the care recipient.

**146. Warrant to take care recipients refusing to comply with court order**—(1) A District Court Judge or (if no Judge is available) a Registrar may issue a warrant in the prescribed form authorising any member of the police to search a specified place and take a named person to a facility, if the District Court Judge or Registrar is satisfied that there are reasonable grounds for believing that the person—

- (a) Is a care recipient who has refused to comply with a court order made under **section 58** or **section 73**; and
- (b) Is in the place that is to be specified in the proposed warrant.

(2) A warrant under **subsection (1)** can only be issued on an application, in writing, made on oath by the Co-ordinator.

(3) A member of the police who executes a warrant under **subsection (1)** may do so with any assistance from the Co-ordinator that the member of the police requests.

(4) A warrant under **subsection (1)** authorises the member of the police who is executing it and the Co-ordinator who may be required to assist the member of the police—

- (a) To enter and search at any time the place specified in the warrant; and
- (b) To remove the care recipient from that place and to take him or her to the facility that he or she is required to attend or stay at in accordance with the relevant order; and
- (c) To use any reasonable force that may be required to carry out any action referred to in **paragraph (a)** or **(b)**.

**147. Matters to be observed when place entered**—A member of the police who enters a place under any of **sections 144** to **146** must,—

- (a) If the member is not in uniform, produce evidence to the person appearing to be in charge of the place that he or she is a member of the police; and
- (b) Explain the purpose of the entry to that person; and
- (c) Explain to that person the authority of the entry, and, where entry is made with a warrant, show the warrant to that person.

*Protection from Criminal Responsibility*

**148. Matters of justification or excuse**—(1) Every person is protected from criminal responsibility for anything done or omitted in good faith and in reliance on a document appearing to be—

- (a) An interim order; or

- (b) A compulsory care order; or
- (c) An order (other than a compulsory care order) made under the Criminal Justice Act 1985, directing that a person be cared for under this Act.

5 (2) The protection given by subsection (1) applies even if the order is defective, as long as the person who relied on the order believed, in good faith and without culpable ignorance or negligence, that the order was good in law; and in this case ignorance of the law is an excuse.

10 (3) For the purposes of subsection (2), it is a question of law whether in the circumstances a person's belief is based on culpable ignorance or negligence.

15 (4) Sections 30, 31, 34, 39, and 40 of the Crimes Act 1961 apply with any necessary modifications in respect of the power described in each of the sections listed in subsection (5) as if the power were a power of arrest.

(5) The sections referred to in subsection (4) are sections 138 (2), 139 (1) and (2), 143, 144 (4), 145 (3), and 146 (4).

Cf. 1992, No. 46, s. 122

20

## PART 10

### PROCEDURAL PROVISIONS

#### *Which Court?*

25 **149. Jurisdiction of Family Court**—(1) Every application under this Act must be heard and determined in a Family Court.

(2) If an application under this Act needs to be determined within a particular period, and it is not practicable to have the application determined in that period by a Family Court Judge, any District Court Judge may exercise the jurisdiction of the Family Court—

- (a) By hearing the application, if that is necessary; and
- (b) By determining the application.

Cf. 1992, No. 46, s. 17

#### *Persons Entitled to be Heard*

35 **150. Persons entitled to be heard on applications**—(1) The following persons may appear and be heard at every hearing of an application that relates to a care recipient:

- (a) The care recipient;
- (b) Any welfare guardian of the care recipient;
- 40 (c) The principal caregiver of the care recipient;
- (d) If the care recipient is a child or young person, each parent or guardian of the child or young person:

- (e) If the care recipient is a child or young person who is not residing with any of his or her parents or guardians, any person—
- (i) With whom the care recipient is living in a place other than a facility; and 5
  - (ii) Who has had the care of the care recipient for a period of not less than 6 months immediately before the application was made:
- (f) Any lawyer of the care recipient:
- (g) Any applicant whose application initiated the assessment under **Part 4** that immediately preceded an interim order or compulsory care order made in respect of the proposed care recipient: 10
- (h) The Co-ordinator:
- (i) The responsible district inspector: 15
  - (j) Any other person who the Court considers should be entitled to appear and be heard because of that person's interest in the welfare of the proposed care recipient.
- (2) **Subsection (1) (a)** is subject to **sections 156 and 157.** 20

**151. Specialist assessors entitled to appear and be heard on certain applications**—(1) A specialist assessor who has completed the most recent certificate under **section 109** relating to the status of a proposed care recipient is entitled to appear and be heard at every hearing of an application of a class specified in **subsection (2).** 25

- (2) The classes of application referred to in **subsection (1)** are—
- (a) An application under **section 76** for a variation of a compulsory care order:
  - (b) An application under **section 114** for a cancellation of a care recipient's court order: 30
  - (c) An application under **section 115** for an extension of a compulsory care order.

**152. Care manager entitled to appear and be heard on certain applications**—The care manager of a care recipient is entitled to appear and be heard at every hearing of— 35

- (a) An application under **section 76** for a variation of the compulsory care order of that care recipient:
- (b) An application under **section 114** for a cancellation of a care recipient's court order of that care recipient: 40
- (c) An application under **section 115** for an extension of the term of a compulsory care order of that care recipient.

**153. Entitlement to be served with application—**

5 (1) When an application under this Act is filed in a Family Court, every person (other than the applicant) who is entitled to appear at a hearing of the application is entitled to be served with a copy of the application and any affidavit filed in support of the application.

10 (2) If a person cannot be served with a copy of an application in accordance with subsection (1), the Family Court may, on such terms and conditions as it thinks fit, dispense with service on that person.

**154. Obligations of district inspector on receiving copy of application—**

15 (1) The responsible district inspector who is served with a copy of an application under this Act must consider whether to appear and be heard at the hearing of the application.

(2) In considering that question, the district inspector must talk to the care recipient, and (where that can be done) ascertain his or her wishes on the matter.

**155. Attendance at hearing by care recipient, and person in support—**

20 (1) The care recipient must be present throughout the hearing of every application unless,—

25 (a) In the case of an application for a compulsory care order, the Judge who examines the care recipient in accordance with section 69 certifies that it would be in the best interests of the care recipient to excuse the care recipient from attending the hearing; or

(b) The care recipient is excused or excluded by the Court under section 156.

30 (2) The care recipient may be supported at the hearing of an application by a person nominated by the care recipient or by the care recipient's guardian, principal caregiver, or friend.

(3) A person nominated under subsection (2) is not entitled to be heard at the hearing, unless the person is otherwise entitled to be heard.

35 Cf. 1992, No. 46, s. 19 (1)

**156. Excusing or excluding care recipient—**(1) The Court may excuse the care recipient from the hearing of an application if it is satisfied that the care recipient wholly lacks the capacity to understand the nature and purpose of the application, or that attendance or continued attendance is likely to cause the care recipient serious mental, emotional, or physical harm.

(2) The Court may exclude the care recipient if it is satisfied that the care recipient is causing a disturbance that makes it impracticable to continue with the hearing in his or her presence.

(3) A discretion conferred by this section may be exercised at any stage of the hearing. 5

Cf. 1992, No. 46, s. 19 (2)-(4)

**157. Representation of persons entitled to be heard, and special rights of care recipient**—(1) Every person who is entitled to appear and be heard at a hearing of an application may be represented by a lawyer, and may call witnesses, and may cross-examine every witness called by another party to the proceeding. 10

(2) If the care recipient is present and appears capable of addressing the Court, the Court must give the care recipient an opportunity to do so. 15

(3) While the care recipient is addressing the Court under subsection (2), the Court may, if it thinks it desirable to do so, require any of the following persons to withdraw from the Court: 20

- (a) A parent of the care recipient:
- (b) A guardian of the care recipient:
- (c) A person with whom the care recipient is living:
- (d) An employee or agent of a service:
- (e) A lawyer representing a person referred to in any of paragraphs (a) to (d). 25

Cf. 1992, No. 46, s. 20

**158. Appointment by Court of lawyer to represent care recipient**—(1) The Court may, if the Court is satisfied that it is necessary or desirable to do so, appoint a lawyer to represent the care recipient. 30

(2) If the Court appoints a lawyer under subsection (1) to represent a care recipient who is a child or young person, it must, so far as practicable, appoint a lawyer who is, by reason of personality, cultural background, training, and experience, suitably qualified to represent the child or young person. 35

(3) A lawyer appointed under this section may call witnesses, and may cross-examine every witness in the proceeding.

(4) Fees for professional services provided by lawyers appointed under this section, and reasonable expenses incurred,— 40

- (a) May be determined in accordance with regulations made under this Act; and



(b) Are payable out of public money appropriated by Parliament for the purpose.

5 (5) The bill of costs rendered by a lawyer appointed under this section must be given to the Registrar of the Court in which the proceeding was heard, and the Registrar may tax the bill of costs.

10 (6) If the lawyer is dissatisfied with the decision of the Registrar as to the amount of the bill of costs, the lawyer may, within 14 days after the date of the decision, apply to a Family Court Judge to review the decision; and the Judge may confirm the decision or vary the decision in a way that the Judge considers fair and reasonable.

Cf. 1980, No. 94, s. 162 (1)-(5); 1989, No. 24, s. 159 (2)

**159. Court may call for report on care recipient—**

15 (1) The Court—

(a) May, if it is satisfied that it is necessary for the determination of an application under this Act, request a qualified person to prepare a report on any matter relating to the care recipient that the Court specifies; and

20 (b) Must, if it makes such a request, make an order or decision under subsection (5).

(2) In deciding whether or not to request a report under subsection (1), the Court may ascertain and have regard to the wishes of the care recipient and any other party to the proceeding.

30 (3) The Registrar of the Court must give a copy of a report obtained under this section to the lawyer for the care recipient and to the lawyer for each of the other parties to the proceeding or, if a party is not represented by a lawyer, to that party.

35 (4) The Court must order that a copy of a report given to a lawyer under subsection (3) may not be given or shown to the person for whom the lawyer is acting if the Court has reason to believe that disclosure of the contents of the report may pose a serious threat to the health or safety of the care recipient or of any other person.

(5) Where a person prepares a report under subsection (1), the Court must order either—

40 (a) That a party to the proceeding pay the fees and expenses of that person; or

(b) That those fees and expenses be paid out of public money appropriated by Parliament for the purpose.

Cf. 1992, No. 46, s. 21 (1)-(5)

**160. Evidence on report**—(1) Where a report has been prepared, under section 159, for a proceeding, every party to the proceeding may give evidence on a matter referred to in the report. 5

(2) The Court may call the person making the report as a witness, either on its own initiative or on the application of a party to the proceeding. 10

Cf. 1992, No. 46, s. 21 (6), (7)

**161. Court not bound by rules of evidence**—In a proceeding on an application under this Act, whether at first instance or on appeal or otherwise, the Court may receive any evidence that it thinks fit, whether it is admissible in a court of law or not. 15

Cf. 1992, No. 46, s. 22

**162. Power of Court to call witnesses**—(1) In a proceeding on an application under this Act, the Court may, on its own initiative, call as a witness any person whose evidence may in its opinion be of assistance to the Court. 20

(2) A witness called by the Court under this section has the same privilege to refuse to answer any question that the witness would have had, if called by a party to the proceeding.

(3) A witness called by the Court under this section may be examined and re-examined by the Court, and may be cross-examined by or on behalf of any party to the proceeding. 25

(4) Sections 20, 38, and 39 of the Summary Proceedings Act 1957, so far as they are applicable and with all necessary modifications, apply with respect to a person called as a witness by the Court under this section as if that person had been called by a party to the proceeding. 30

(5) The expenses of a witness called by the Court under this section must be paid in the first instance, in accordance with the prescribed scale of witnesses' expenses, out of public money appropriated by Parliament for the purpose. 35

Cf. 1992, No. 46, s. 23

**163. Proceedings not open to public**—(1) No person may be present during a hearing under this Act except the following: 40

(a) The Judge:

- (b) Officers of the Court:
- (c) Parties to the proceeding and their lawyers, any person entitled under this Act to appear at the hearing, and any other person nominated by the proposed care recipient:
- 5 (d) Witnesses:
- (e) Any other person whom the Judge permits to be present.
- (2) A witness must leave the courtroom if asked to do so by the Judge.
- 10 (3) Nothing in this section limits any other power of the Court to hear proceedings in private or to exclude any person from the Court.

Cf. 1992, No. 46, s. 24

15 **164. Restriction of publication of reports of proceedings**—(1) No person may publish a report of proceedings under this Act except with the leave of the court that heard the proceedings.

(2) Every person who contravenes subsection (1) commits an offence and is liable to a fine not exceeding \$10,000.

20 (3) Nothing in this section limits—

(a) The provisions of any other enactment relating to the prohibition or regulation of the publication of reports or particulars relating to judicial proceedings; or

(b) The power of a court to punish any contempt of court.

25 (4) Nothing in this section applies to the publication of—

(a) Any report in any publication that—

(i) Is genuinely of a professional or technical nature; and

30 (ii) Is intended for circulation among persons appointed or designated under Part 12, members of the legal or medical professions, psychologists, officers of the Public Service, or social welfare workers:

(b) Statistical information relating to proceedings under this Act:

35 (c) The results of any genuine research relating to proceedings under this Act, as long as the publication does not include any name or particulars likely to lead to the identification of any of the parties to the proceedings, or of any other person to whom the proceedings relate.

40

Cf. 1992, No. 46, s. 25; 1995, No. 86, s.125 (4)

**165. Court may dispense with hearing in certain circumstances**—Despite any other provision of this Part, the

Court may determine an application without a formal hearing if it is satisfied that no person wishes to be heard in respect of the application.

Cf. 1992, No. 46, s. 26

**166. Care recipient to be given copy of order**—After a court has made an order on an application under this Act, the Registrar of the Court must give or send the care recipient and the care recipient's lawyer and any guardian of the care recipient a copy of the order. 5

*Appeals* 10

**167. Appeals from decisions of Family Courts**—(1) Where, in a proceeding under this Act, a Family Court has made or has refused to make an order, or has otherwise determined or has dismissed the proceeding, a party to the proceeding may, within 28 days after the making of the order or decision or within such further time as the High Court may allow, appeal to the High Court. 15

(2) Sections 74 to 78 of the District Courts Act 1947 apply to every appeal under subsection (1) with any necessary modifications. 20

(3) The decision of the High Court on an appeal to that Court under subsection (1) is final.

Cf. 1980, 94, s. 174 (1), (8)

**168. Further appeal to Court of Appeal**—(1) Despite section 167 (3), a party to an appeal under that section may, with the leave of the Court of Appeal, appeal to the Court of Appeal against a determination of the High Court on a question of law arising in an appeal under that section. 25

(2) On an appeal to the Court of Appeal under this section, the Court of Appeal has the same power to adjudicate on the proceeding as the High Court had. 30

(3) The decision of the Court of Appeal on an appeal, and on an application for leave to appeal, is final.

Cf. 1980, No. 94, s. 174 (5)–(7)

**169. Orders stay in force during appeal**—The fact that an appeal has been brought against an order made under this Act does not affect the operation of the order, and every person to whom the order applies continues to be bound by it during the appeal period. 35

Cf. 1980, No. 94, s. 174 (9) 40

PART 11

RELATIONSHIP WITH OTHER ACTS

**170. Application to mentally disordered persons—**

5 (1) No compulsory care order may be made in respect of a person who is a patient or proposed patient within the meaning of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

10 (2) If a care manager has reason to believe that a care recipient may have developed a mental disorder, the care manager must apply to have the care recipient assessed under section 8 of that Act.

(3) If a care recipient subject to a compulsory care order becomes a proposed patient within the meaning of the Mental Health (Compulsory Assessment and Treatment) Act 1992,—

15 (a) The care recipient's compulsory care order is suspended on the date of that occurrence; and

(b) The care recipient's care manager must keep a record of the date of the suspension and of the unexpired term of the care recipient's compulsory care order.

20 (4) A compulsory care order that is suspended in accordance with subsection (3) (a) is revived and continues to run on the date on which the care recipient ceases to be a proposed patient within the meaning of the Mental Health (Compulsory Assessment and Treatment) Act 1992 or is released from compulsory status under that Act.

25 (5) During the period that a special care recipient is subject to compulsory status under the Mental Health (Compulsory Assessment and Treatment) Act 1992,—

30 (a) The special care recipient must be held as a special patient under that Act; and

35 (b) If the special care recipient is subject to an order under section 115A (2) (b)<sup>15</sup> of the Criminal Justice Act 1985, the order must be treated for the purposes of sections 77 and 80 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and sections 116A and 117<sup>16</sup> of the Criminal Justice Act 1985 as an order under section 115A (2) (a)<sup>17</sup> of the Criminal Justice Act 1985; and

<sup>15</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

<sup>16</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

<sup>17</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

- (c) Any direction given during that period under section 116A or section 117<sup>18</sup> of the Criminal Justice Act 1985 that the special care recipient be held as a patient must be treated, on the return of that person to a facility, as a direction that the person be held as a civil care recipient. 5

**171. Orders under Protection of Personal and Property Rights Act 1988**—(1) An order made under the Protection of Personal and Property Rights Act 1988 in respect of a person does not stop the application of the provisions of this Act to that person. 10

(2) To the extent of any inconsistency,—

(a) A provision of this Act prevails over a provision of the Protection of Personal and Property Rights Act 1988; and 15

(b) A power or other form of authority conferred under this Act prevails over a power or other form of authority conferred under that Act.

**172. Orders under Children, Young Persons, and Their Families Act 1989**—(1) An order made under the Children, Young Persons, and Their Families Act 1989 in respect of a child or young person does not stop the application of the provisions of this Act to that child or young person. 20

(2) A compulsory care order in respect of a child or young person does not preclude the making of an order under Part II of the Children, Young Persons, and Their Families Act 1989 in respect of that child or young person. 25

(3) To the extent of any inconsistency,—

(a) A provision of this Act prevails over a provision in Part II of the Children, Young Persons, and Their Families Act 1989; and 30

(b) A power or other form of authority conferred under this Act prevails over a power or other form of authority conferred under Part II, or sections 347 and 348, of the Children, Young Persons, and Their Families Act 1989. 35

**173. Certain orders under Criminal Justice Act 1985 prevail over orders under this Act**—(1) If a person becomes

<sup>18</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

subject to an order under section 121 (2) (c) or section 121E (1) <sup>19</sup> of the Criminal Justice Act 1985, any order under this Act in respect of that person is suspended during the currency of that order under the Criminal Justice Act 1985.

- 5 (2) A compulsory care order of a care recipient ceases to have effect if, after the order is made, the care recipient—
- (a) Becomes subject to an order made under section 115A (2) or section 118 (1) <sup>20</sup> of the Criminal Justice Act 1985; or
  - (b) Is sentenced by a court to be detained in a prison.

10

PART 12

ADMINISTRATION

**174. Compulsory Care Co-ordinators**—(1) The Director-General must—

- 15 (a) Appoint as many Compulsory Care Co-ordinators as the Director-General considers necessary; and
- (b) Determine the geographical areas for which Compulsory Care Co-ordinators are responsible; and
- 20 (c) Determine the terms and conditions on which each Compulsory Care Co-ordinator is appointed, including every operational area for which each Compulsory Care Co-ordinator is responsible.

(2) The Director-General—

- (a) May appoint Compulsory Care Co-ordinators from time to time; and
- 25 (b) May appoint Compulsory Care Co-ordinators to replace previously appointed Compulsory Care Co-ordinators; and
- (c) Must publish a notice in the *Gazette* notifying each appointment and the geographical and operational
- 30 areas for which the appointee is responsible.

(3) A person appointed under this section may at any time be suspended or removed from office by the Director-General for neglect of duty, misconduct, bankruptcy, or disability affecting his or her duties proved to the satisfaction of the Director-

35 General.

Cf. 1992, No. 46, s. 92

**175. Designation of care manager**—(1) The Co-ordinator must designate a care manager for every care recipient—

<sup>19</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

<sup>20</sup> As included in a new Part 7 of the Criminal Justice Act 1985 proposed to be substituted by clause 16 of the Criminal Justice Amendment Bill (No. 7)

(a) For whom an assessment is initiated in accordance with section 33; or

(b) Who becomes subject to a Court order, and who does not have a care manager designated under paragraph (a).

(2) The Co-ordinator may at any time, by notice to the individual concerned, revoke a designation under subsection (1) and designate another individual as the care manager of the care recipient. 5

(3) The individual designated under subsection (1) or subsection (2) must be an employee or agent of a service. 10

(4) When the Co-ordinator designates a care manager for a care recipient or revokes a designation, the Co-ordinator must follow every relevant direction contained in the care recipient's court order.

**176. Co-ordinator or care manager may delegate powers—**(1) Every Co-ordinator and every care manager may each delegate any of his or her respective powers, duties, and functions, except this power of delegation, to a person who is suitably qualified to exercise them. 15

(2) The maker of the delegation must make the delegation in writing and sign it. 20

(3) The maker of the delegation is not prevented from exercising, or affected in his or her exercise of, any of the delegated powers, duties, or functions.

(4) The delegate may exercise the powers, duties, and functions in the same manner and with the same effect as if they had been conferred on the delegate directly by this Act. 25

(5) Every person purporting to act under a delegation is, in the absence of proof to the contrary, presumed to be acting in accordance with the terms of the delegation. 30

**177. Status of delegations—**(1) A delegation made under section 176 continues in force according to its tenor until it is revoked.

(2) If the maker of the delegation ceases to hold office, the delegation continues to have effect as if made by the successor of the office holder. 35

(3) The maker of the delegation, or successor, may revoke the delegation at any time by written notice to the delegate.

**178. Remuneration of district inspectors—**The Minister may from time to time, with the concurrence of the Minister of Finance, fix the remuneration of district inspectors for work performed under this Act, either generally or in any particular 40



case, and may also, with the concurrence of the Minister of Finance, vary the amount or nature of that remuneration.

- 179. No proceedings against district inspectors unless bad faith shown**—(1) No civil proceedings may be brought  
5 against a district inspector for any thing he or she may do or report or say in the course of the exercise or performance or intended exercise or performance of his or her powers, duties, or functions under this Act, unless it is shown that he or she acted in bad faith.
- 10 (2) Nothing in this section affects the right of a person or organisation to apply, in accordance with law, for judicial review of the exercise or performance of a district inspector's powers, duties, or functions under this Act.

- 180. Designation of specialist assessors and medical consultants**—The Director-General may from time to time,  
15 by notice in writing, designate—
- (a) Health or disability professionals who are experts on intellectual disability as specialist assessors for the purposes of this Act; and
- 20 (b) One or more medical practitioners as medical consultants for the purposes of section 98 (3).

*Standards, Rules, and Regulations*

- 181. Director-General may promulgate guidelines and standards**—(1) The Director-General of Health may from time  
25 to time issue—
- (a) Guidelines for the purposes of this Act; and  
(b) Standards of care and treatment of care recipients.
- (2) All guidelines and standards issued under subsection (1) are regulations for the purposes of the Regulations (Disallowance)  
30 Act 1989, but are not regulations for the purposes of the Acts and Regulations Publication Act 1989.

Cf. 1992, No. 46, s. 130

- 182. Rules**—(1) In addition to all other powers conferred by the District Courts Act 1947, the Governor-General may from  
35 time to time, by Order in Council, make rules—
- (a) Regulating the practice and procedures of Family Courts in proceedings under this Act; and
- (b) Providing for such other matters as are contemplated by  
40 or necessary for giving full effect to the provisions of this Act and for its due administration.

(2) In the absence of any rules under this section or in any situation not covered by the rules, the rules in relation to civil proceedings for the time being in force under the District Courts Act 1947 apply, with all necessary modifications, to proceedings under this Act. 5

**183. Regulations**—The Governor-General may from time to time, by Order in Council, make regulations for all or any of the following purposes:

- (a) Prescribing forms for the purposes of this Act:
- (b) Prescribing the powers and duties of district inspectors, and regulating the exercise of such powers and the performance of such duties: 10
- (c) Regulating the management of secure care facilities:
- (d) Making provision for determining the amount of fees and expenses, including minimum and maximum amounts, payable in respect of professional services provided by lawyers appointed under section 158 or qualified persons appointed under section 159, and those fees and expenses may differ according to— 15
  - (i) The complexity of the proceeding and the time spent; and 20
  - (ii) Whether or not professional services are to be provided in a specified number of proceedings during a specified period:
- (e) Providing for such other matters as are contemplated by or necessary for giving full effect to the provisions of this Act and for its due administration. 25

# Indefinite term for paedophilia

A High Court judge said yesterday that he saw no prospect of it ever being safe to give a convicted paedophile his liberty.

Justice Sir Graham Speight made his comments as he sentenced former Kingsseat Hospital patient Dennis Wayne Miller, of Mangere East, to preventive detention.

Miller, said to be one of 37 psychiatric patients released from hospital because of a loophole in the law, earlier admitted a charge of sexual violation by unlawful sexual connection involving a five-year-old boy in the grounds of Middlemore Hospital on February 20.

Miller's lawyer, Mr Chris Field, told the judge that Miller was released from Kingsseat in January despite the "grave reservations" of his psychiatrist who said he was at risk of offending.

With hindsight, releasing him into the care of his family was a mistake.

Before the offending Miller smoked cannabis, which Mr Field said was provided by a member of his family, and also drank some alcohol which released his inhibitions.

He then committed the offence against the young boy.

Mr Field said that in June last year Miller had been allowed on

leave from Kingsseat and for some of that time he was unsupervised.

He said that Miller had been a special patient. (People unfit to stand trial become special patients. They are held until considered fit to be let out.)

The focus of Miller's attentions was on younger people rather than adults.

Although he had committed this type of offence before, this would be his first time in prison for such offending.

Mr Field said that Miller was intellectually handicapped: he had not had much schooling, could not read, write or tell the time, and had no idea about months or years.

He had been in psychiatric hospitals since the age of 12.

Mr Field said that Miller had been physically and sexually abused by more than one person as a child, something which was now being investigated by the police.

Though 37 years of age, Miller had a mental age much closer to that of his victims.

Mr Field said that while the concern of the court would be to protect the public, Miller himself was a victim.

Abused since childhood, he had now been abandoned by his family; there had been assaults on him and death threats against him in custody.

Mr Field said that Miller was motivated to change and would undertake counselling while in jail. He asked for him to be given a finite prison term.

Sir Graham said that Miller's mental disability, his past life and present circumstances filled one with compassion, but that paled in comparison to the tragedy which he had inflicted on the victim in this case and other young people who had suffered at his hands.

Miller had a history of offending against children in the past in the very gravest circumstances and he had repeated it in this case.

However, because of his mental condition he had never previously gone to trial, but had spent a substantial period of his life in psychiatric hospitals.

While Miller's situation was grim, the protection of the public was paramount.

Sir Graham said he could see no prospect of it ever being safe to give Miller his liberty.

He said that preventive detention was indefinite custody designed for those considered too dangerous to have at liberty now or in the foreseeable future.

The gravest task fell on those charged with the unenviable task of considering whether it would ever be safe to release Miller from jail.

## 54 people given indefinite sentences

Fifty-four violent criminals are being held indefinitely in prisons, having been sentenced to preventive detention.

The sentence, New Zealand's ultimate custodial sanction, was imposed yesterday on Dennis Miller, who had sodomised a five-year-old boy in the grounds of Middlemore Hospital in February.

A Justice Department spokesman said yesterday that several of the 54 offenders had been behind bars for more than 20 years.

"Some may never be released. They will die in prison."

Every other prison sentence, including life terms, had a finite period.

## Land court appointment

NZPA Hamilton

The Maori Land Court has a new deputy chief judge.

He is Judge Norman Smith, a Maori Land Court judge, formerly of Rotorua.

Hark  
Seafoam



of Windsurfers  
Skis and Sl  
Surfboards  
Snowboard  
Waveskis  
Wetsuits  
Surf Clothing  
Accessories

Every  
at Hauraki

ALL WEEK  
AP

Indefinite term for paedophilia

Appendix B

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